Berkshire Healthcare
NHS Foundation Trust

ANNUAL REPORT AND ACCOUNTS

2024/25

Berkshire Healthcare NHS Foundation Trust
Annual Report and Accounts 2024/25

Presented to Parliament pursuant to Schedule 7, paragraph 25 (4) (a) of the National Health Service Act 2006

Annual Report & Accounts 2024/25

CHAIR AND CHIEF EXECUTIVE'S REPORT 2024-25

This year saw the new Government set out its priorities for the NHS. The Secretary of State for Health and Social Care was clear on the three themes:

- Treatment to prevention
- Acute to community
- Analogue to digital

Later in the year, the Government made clear the scale of financial restraint. The Government also announced the decision to integrate NHS England with the Department of Health and Social Care with significant staff reductions and the halving of the size of the Integrated Care Boards.

We are in a time of substantial change. But we are fortunate that Berkshire Healthcare has put in place strong foundations in the way it manages its affairs to be well placed to respond positively to these challenges. Our clinical care remains strong and importantly, the culture of learning from problems that from time to time occur is central to continually improving our services.

Neurodiversity remains a significant area of concern, where autism assessments are taking too long due to the very high demand. But even here, our waiting times, whilst too long, are significantly better than before with innovative approaches to meeting the demand.

Our financial performance remains strong with the Trust achieving a surplus yet again. In part, this is due to purposeful management and the empowerment of our teams throughout the Trust.

Digital services are also of a high standard, and we are making full use of our capabilities, including automating administrative processes. Importantly, the availability of data from our connected care digital systems are giving us a detailed understanding of the health inequalities across Berkshire and enabling us to target areas of most concern.

Perhaps the principal factor underpinning the excellent performance of the Trust is the culture. It is purposeful, compassionate and evidence based. A measure of this success can be seen in the staff engagement scores in the annual NHS national staff survey. The scores are not only the highest of those of comparative providers, but among the best of all NHS providers in England.

In previous years, our progress on supporting our Black staff whilst well intentioned has been less satisfactory than our overall achievement. However, this year the Black and Asian staff now have even higher engagement scores than the high levels of our white staff. This is a very pleasing result, and credit goes to the executive for implementing our revised anti-racism programme so well.

I am grateful to all staff for their commitment to delivering high quality care and their determination to always seek better ways of doing so.

Returning to the Government's themes, I have shown that we are financially sound with excellent digital processes enabled by supportive staff and delivering outstanding care. The move from acute to community is something that needs the engagement of our partners in the two Integrated Care Boards of which we are a part.

We already work closely with the Royal Berkshire Hospital and Frimley Health in creating integrated pathways between acute and community care. I am sure working together even closer across the system; we will be able to do more and reap the benefits of better care and more effective use of resources.

This year has also seen changes to our Board. Dr Minoo Irani, our medical director retired at the end of March 2025. Minoo has been an outstanding executive and will be greatly missed. I am pleased that he has been appointed as a non-executive director of the Royal Berkshire NHS Foundation Trust, which will help our already close working between the two trusts.

We were delighted to welcome Dr Tolu Olusoga as the new medical director who I know will be a worthy successor to Minoo. We have also said farewell to Tehmeena Ajmal, our Chief Operating Officer who has moved to an exciting new role in the Welsh NHS. Theresa Wyles, our Director for Mental Health Services has been appointed as interim Chief Operating Officer.

We will shortly be saying farewell to Naomi Coxwell, who has been an outstanding Non-Executive Director for over seven years and has chaired the Finance, Investment and Performance Committee with distinction.

It is a real pleasure to acknowledge the outstanding leadership of Julian Emms, our chief executive, who has been made OBE in the recent new year honours. This is richly deserved, and our thanks go to him for his never-ending commitment to our patients, our staff, and the communities we serve.

Finally, I shall be retiring as chair of the Trust in July 2025 after over 8 years in the role. I shall be very sad to leave and am grateful for the support of my board colleagues, the governors and the staff.

I have seen the Trust grow over the years facing the challenges with confidence willing to make the necessary decisions based on evidence, building a truly compassionate culture, focusing on our patients and always doing the right thing. It leaves me confident that the Trust is well placed to meet whatever challenges it will face.

It has been a privilege for me to have shared in this journey.

Martin Earwicker	Julian Emms
Trust Chair	Chief Executive
18 June 2025	18 June 2025

PERFORMANCE REPORT

Overview

The purpose of this section is to provide an understanding of the Trust, as well as setting out our performance in 2024-25.

Brief History and Summary Information

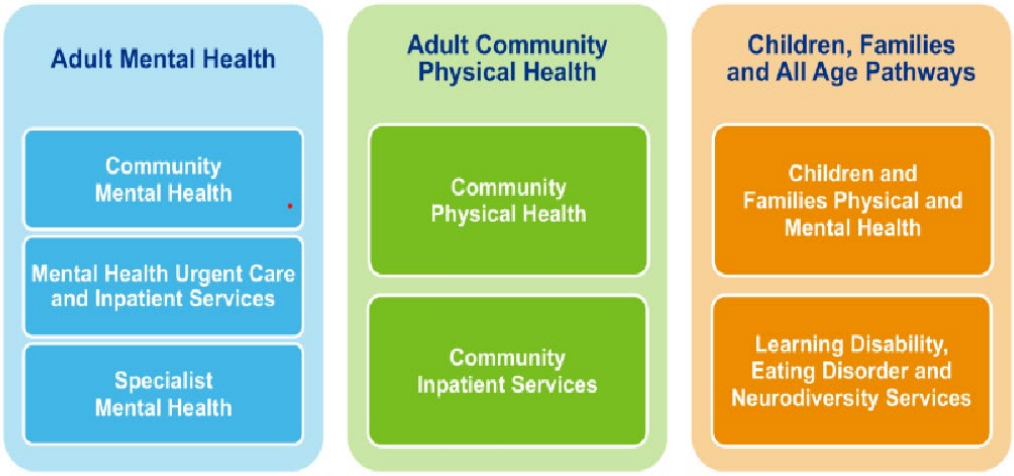
Berkshire Healthcare NHS Trust was established in 2001. The Trust successfully gained NHS Foundation Trust status in May 2007. The Trust was issued with its provider licence in April 2013. In line with the Trust's provider licence, the principal purpose of the Trust is the provision of goods and services for the purposes of the health service in England.

The Trust is the main provider of mental health and community health services to a population of around 900,000 people across Berkshire. We operate from over 100 sites in various settings across Berkshire and the neighboring counties. The majority of our healthcare and therapy services are provided to people within their own homes.

The Trust employs approximately 6,000 permanent staff which includes doctors, registered and non-registered nurses, therapists, psychologists and both clinical and non-clinical support staff. We work with our health and social care partners across two Integrated Care Systems: Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System and Frimley Health and Care Integrated Care System.

Our services in Reading, West Berkshire and Wokingham are commissioned by Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System, and services in Bracknell, Slough, Windsor and Maidenhead by Frimley Health and Care Integrated Care System. In addition, there are a few services commissioned by NHS England and NHS Specialist Commissioning. In addition, to our NHS partners, the Trust works with our six local unitary authorities, West Berkshire, Reading, Wokingham, Windsor and Maidenhead, Slough and Bracknell Forest, delivering services to children and young people in schools and children's centres, providing a range of specialist services and home visits.

In 2023, we changed our operational structure, moving our services from six divisions into three (see overleaf). The divisions operate across Berkshire (and beyond for services with a wider footprint). However, services continue to be delivered locally by teams working with their local partners and within existing clinical pathways and relationships.



In addition to these services, we operate a Mental Health Inpatient service at Prospect Park Hospital in Reading. All these services are supported by our central corporate teams.

In November 2019, the Trust underwent a comprehensive Inspection by the Care Quality Commission which resulted in the Trust being awarded an overall "Outstanding" rating, including outstanding in the well-led domain.

Ratings

Overall trust quality rating	Outstanding ☆
Are services safe?	Good ●
Are services effective?	Good ●
Are services caring?	Good ●
Are services responsive?	Outstanding ☆
Are services well-led?	Outstanding ☆

We remain immensely proud of this achievement, and it is testament to the hard work and dedication of all our staff that we have achieved this result.

Our Trust Vision and Values

Our high-level priorities are to:

Continue to improve access, quality, and experience of care for our patients

- *Delivering outstanding patient care*
- *Improving patient safety*
- *Improving health outcomes and experiences*

Work with partners to improve the health outcomes of our populations

- *Providing integrated care closer to home*
- *Improving the health and wellbeing of our communities*
- *Delivering sustainable services*

Make Berkshire Healthcare a great place to work for our people

- *Looking after our staff*
- *Belonging to the Trust*
- *New ways of working and delivering care*
- *Collaborating across our health and social care systems*

Our strategy for 2023-2025 will continue building on the objectives set in recent years while addressing the evolving circumstances impacting the Trust and our patients, populations, and people. The five key themes of this strategy are:

- To continually improve patient safety and reduce waiting times
- To actively listen to our patients' experiences and voices, increase patient satisfaction and co-design services where we can
- To reduce health inequalities for our most vulnerable patients and communities
- To make our organisation a great place to work for everyone
- To use our resources efficiently and focus on long-term investments

We have set clear targets against each of these strategic themes and performance against these targets is monitored and reported to our Trust Board.

Performance Overview

We have seen the demand for our Community and Mental Health services continue to increase over the past year, whilst at the same time, we are operating under significant financial constraints. We have continued to focus our resources on meeting the needs of our local population. Over the past year, we have successfully balanced providing high quality clinical services, whilst effectively managing within our financial resources.

We have worked hard and have brought down long waits for services across the Trust and are committed to bringing them down further. This is an on-going focus for the Trust and an area which we expect to make continued improvements.

This has been another hugely successful year for the Trust and a number of our staff and teams have received local and national recognition for their continuing commitment and dedication. These include:

- Our Chief Executive, Julian Emms, was awarded an Officer of the Order of the British Empire (OBE) in the New Year Honours List. This well-deserved recognition for services to the NHS celebrates Julian's incredible contributions to healthcare and his commitment to improving lives across Berkshire.

- We were 'Highly Commended' in the 'Trust of the Year' category at the Health Service Journal Awards, recognising our outstanding contribution to mental and community healthcare across the county. We also celebrated a win for the Data-Driven Transformation Award, which went to the Southeast Temporary Staffing Collaborative, a project led by our Chief Executive, Julian Emms. The Health Service Journal Awards is the largest annual benchmarking and recognition programme for the health sector.

- The Diabetes Specialist Service has won an award for Outstanding Collaboration by the National Diabetes Audit (NDA) Quality Improvement Collaborative. The NDA supports improvements in the quality of diabetes care with participating NHS services, and the award was given for the team's support to the collaborative and other Diabetes Centres nationally.

- Our work delivering the innovative Managing Heart Failure@home project has been 'Highly Commended' in the 'Best Consultancy Partnership with the NHS' category at the Health Service Journal Partnership Awards 2025. The Health Service Journal Partnership Awards recognise the vital partnerships between the NHS and suppliers of goods and services.

- We have retained our Level 3 Disability Confident Leader Status showing our commitment to supporting disabled colleagues and creating an inclusive workplace. The Disability Confident Scheme, a government initiative, encourages employers to improve how they attract, recruit, and retain disabled workers.

- The Communications team won The Middle Aisle Award at the CommsHERO awards. This award recognises how the Trust has used social media to share patient stories and offer a compassionate approach to sensitive topics. The commsHERO Awards celebrate individuals and teams in the marketing community who have demonstrated innovation and excellence across the communications sector.

- Our work supporting individuals from the Armed Forces community in joining the NHS has been highly commended in the Transition Support category at the Step into Health awards. The Step into Health awards recognises those who have gone above and beyond to help those taking the step from the Armed Forces community into the NHS.

- Mandy Proctor celebrated 50 years in the NHS. Mandy started her journey with us at Upton Hospital on 3 September 1974 and has worked at various sites throughout the years. In September 2024, the Chief Executive presented a special 50 years of service award to Mandy. While presenting the award, the Chief Executive said: "We have some remarkable people in the NHS, but Mandy's 50 years of NHS service is an extraordinary landmark. It is both a pleasure and a privilege to recognise such outstanding public service."

- We have been awarded the Race Equality Matters Silver Trailblazer Status. This award recognises our ongoing commitment to being an anti-racist organisation. Rather than starting at the bronze level, we have been awarded silver status, which is valid for two years and is currently the highest available award.

- Jeff and Suzanne Whitton were shortlisted for the Carers Award category in BBC Radio Berkshire's Make a Difference Awards, for their role in helping create a new

carers programme at the Trust. The award recognises those who improve the life of an individual or group of people through their helpfulness, compassion and support.

We recognise and encourage patient and carer feedback about our services. We employ the iWantGreatCare tool across our services to provide meaningful and detailed feedback which our services can evaluate to drive improvements. Driving up response rates and attaining a positive patient score of 95%+ are key driver metrics that we closely monitor.

Staff well-being remains at the heart of our organisation, and we have continued to do everything we can to support our staff and make everyone feel valued. The national NHS Staff Survey is an important barometer for us to check how we are performing against NHS England's People Promise and for the fifth year in a row we are the top-ranked NHS Mental Health provider in the country, and in the national top five of all NHS providers, for staff recommending us as a place to work.

We have continued our commitment to providing high quality services that meet the requirements of our Care Quality Commission registration and in compliance with the conditions of our provider licence.

We ended 2024-25 with an adjusted surplus of £4.9m. This was better than our planned £1.9m surplus performance and in line with our commitment to perform better than planned to support the overall financial position within the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board.

The Trust closed with a cash balance of £54m, a £1.4m increase in year. During the year, we continued to invest in our estate and IT infrastructure and spent a total of £11.5m.

The Trust continues to work closely with partner organisations in the Frimley Health and Care Integrated Care System and the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System, of which we are a member. This includes working with partner organisations on the delivery of the Integrated Care System objectives and contributing to forward plans where required, including the joint capital forward plan. Further information can be found on the Integrated Care Systems websites at https://bucksoxonberksw.icb.nhs.uk/ and https://frimleyhealthandcare.org.uk/

The Trust Board is responsible for preparing this Annual Report and the Annual Accounts and the Trust Board considers that the Annual Report and Accounts, taken as a whole, to be fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS Foundation Trust's performance, business model and strategy.

The Trust's accounts have been prepared under a direction issued by NHS England under the National Health Service Act 2006. Accounting policies for pensions and other

retirement benefits (as set out in the notes to the accounts) and details of senior employees' remuneration can be found in the remuneration report.

The external auditor for Berkshire Healthcare NHS Foundation Trust, as appointed by the Council of Governors, is Ernst & Young LLP. The Trust's internal auditors are RSM Risk Assurance Services LLP as appointed by the Trust Board.

Principal Risks and Uncertainties

A key role for the Trust Board and the Executive Team is to manage and mitigate risks to the delivery of our strategic objectives. We therefore operate a robust risk management process that ensures that all key risks are identified, and that mitigation action is taken to address these. Our Board Assurance Framework and Corporate Risk Register are regularly reviewed by both the Trust Board and relevant Board Sub-Committee and Executive Groups. A detailed review of our corporate risk and mitigations is included in our Annual Governance Statement.

Our key risks relate to the safety of and quality of care we provide to our patients, as well as to the Trust's financial sustainability. We spend considerable time ensuring that financial pressures do not compromise safety and quality. Our key risks include:

- **Inability to recruit and retain sufficient staff which could impact our ability to meet our commitment to providing safe, compassionate, high-quality care and a good patient experience for our service users.**

Despite national workforce pressures, we have seen our workforce continue to grow over the past year and we have had major progress in reducing our time to hire staff and ended the year with our staff turnover below our target. This continues to be a key area of focus for us and is the focus of our People Strategy, which includes initiatives to grow and develop our existing workforce as well as opportunities for increasing apprenticeships in the organisation and improve our well-being, and reward offers to staff.

- **Failure to achieve our financial targets impacting on our ability to make strategic investments and requirements to increase efficiency requirements on services.**

We set a realistic and stretching financial plan in line with our agreed Integrated Care Board allocations and monitor financial performance against these plans throughout the year, taking corrective actions where and when required.

- **Inability to meet the rising demand for our services due to high referral rates and increased acuity of patients. This risk has been elevated following the pandemic, with rates increasing further, particularly in Mental Health Inpatients, Community**

Nursing, Child and Adolescent Mental Health Services and Common Point of Entry.

We have worked hard all year and have eliminated long waits for services, and through our quality improvement work with our services, we aim to reduce waits further. We have invested new funding into our services to build additional capacity to address growing demand.

- **The failure to "hear the patient voice" and take account of patient experience when shaping, adapting, and designing services leading to services which do not meet the needs of all groups of patients and their families leading to inequality of access and poorer health outcomes.**

We recognise that it is crucial to listen to and learn from our patients, and more importantly engage them when looking at how we can improve the services we provide. We are increasing our lived experience workforce and use of service user co-production in quality improvement.

- **The risk of our network and infrastructure being the subject of malware attack which could compromise systems leading to unavailability of clinical systems, loss of data, ransom demands for data and mass disruption.**

We continue to audit our processes and share our Annual Cyber Security Report with our Audit Committee. We retained our National CyberEssentials+ certification and ultimately continue to invest in our IT Team and infrastructure to defend against this on-going cyber security risk.

Along with our Quality Improvement Programme, we have further strategic initiatives in place to address and mitigate these risks.

Going Concern

After giving due consideration to the principal risks and uncertainties contained in the Board Assurance Framework, Corporate Risk Register, and making additional enquiries wherever deemed appropriate, the Trust Board has a reasonable expectation that the Berkshire Healthcare NHS Foundation Trust has adequate resources to continue in operational existence for the foreseeable future.

For this reason, the directors have adopted the going concern basis in preparing the accounts, following the definition of going concern in the public sector adopted by HM Treasury's Financial Reporting Manual.

Performance Analysis – Monitoring Performance

The Trust Board oversees delivery against our key performance measures and the achievement of strategic objectives. This ensures that the financial and governance requirements of our provider Licence are met, and that the quality and safety of care we provide meets the requirements of the Care Quality Commission.

The Trust takes an integrated approach to performance, measuring itself against targets and benchmarks in clinical care, quality, and finance. Within each, there are a wide variety of measures, but all are monitored and reported using established and robust systems.

Our Performance Assurance Framework is built on the principles of our Trust Quality Improvement Programme. We review our "True North" organisation goals on an annual basis to ensure that at the highest level, the organisation is focused on the same key goals.

Our organisational goals provide the structure for our annual "Plan on a Page" and are supported by specific measures which enable us to focus our efforts and track our progress effectively. We use our Trust "Plan on a Page" as a template to inform both team plans and individual objectives for all our staff. For 2024/25, our "Plan on a Page" set out the following specific measures against each of our goals:

Harm-free care

Providing safe services

- We will protect our patients and staff by using appropriate infection control measures
- We will identify and prioritise patients at risk of harm resulting from waiting times
- We will continue to reduce falls, pressure ulcers, self-harm in in-patient services and suicide across all of our services
- We will recognise and respond promptly to physical health deterioration on all our wards
- We will improve the physical health of people with serious mental illnesses
- We will empower staff and patients to raise safety concerns without fear, and ensure learning from incidents

Supporting our people

A great place to work

- We will promote a culture of respect, compassion and kindness and inclusivity
- We will act against anyone who is verbally, racially, physically, or sexually abusive
- We will act on our anti-racism commitment, removing barriers to equality and improving representation in senior positions
- We will create a supportive work environment that values each team member's

contribution, wellbeing and professional development.

- We will provide opportunities for staff to show initiative and make improvements
- We will reduce staff leaving (no more than 10% by March 2025)
- We will ensure we have a highly skilled permanent and temporary workforce by actively developing staff and proactively attracting great external candidates

Good patient experience

Improving outcomes

- We will identify and reduce health inequalities in access, experience and outcomes
- We will involve patients in co-production of service improvement
- We will reduce length of time patients wait for our services, year on year (compared to 2022 waits)
- We will make every contact count by offering advice in making healthy choices
- We will gain feedback from at least 10% of our patients in each service and demonstrate service improvements based on the feedback

Efficient use of resources

A financially and environmentally sustainable organisation

- We will achieve our financial plan
- We will identify and deliver efficiencies
- We will increase our productivity
- We will reduce our impact on the environmental, minimise waste and reduce carbon emissions.
- We will maximise the use of digital tools to release time to care for and empower patients

Performance Framework

Our Performance Assurance Framework reflects the key drivers of performance set against our 'True North' goals, our tracker metrics, as well as regulatory compliance. This provides a robust structure to track all performance elements and resolve instances when performance is outside of accepted thresholds.

The tables overleaf show our performance against our key Driver Metrics over the year. These are monitored and reported at all public Trust Board meetings, following detailed review and scrutiny at the Finance, Investment and Performance Board sub-committee and the Quality and Performance Executive Group.

Harm Free Care

Metric	Target	External/Internal	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sept 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25
Breakthrough Restrictive Interventions in Mental Health Inpatient Wards	241 from 1st August 2024 previously 309	Internal	213	274	242	263	233	183	186	246	257	284	262	351

Patient Experience

Positive Patient Experience Score %	95% compliance	External	93.67%	94.37%	93.97%	94.19%	94.19%	95.09%	94.19%	95.09%	94.71%	95.19%	95.89%	95.39%
Patient Experience Compliance Rate %	10% compliance	External	7.09%	7.39%	6.5%	5.70%	6.20%	4.39%	4.29%	4.10%	5.24%	5.89%	7.29%	7.79%

			Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sept-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Breakthrough Clinically Ready for Discharge by Wards MH (including OAPS)	250 bed days	External	353	248	351	275	249	248	291	147	186	224	240	301	360

			Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sept-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Breakthrough Bed days occupied by patients who are discharge ready Community	500 bed days	External	554	643	812	999	830	886	876	849	977	890	603	583

Supporting our Staff

Metric	Threshold / Target	External/Internal	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sept 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25
Breakthrough Physical Assaults on Staff	36 per month Sept 2024	Internal	30	38	55	64	47	70	73	38	55	50	47	85
Staff turnover (excluding fixed term posts)	10% by March 2025	External	12.4%	12.60%	12.59%	12.49%	12.32%	12.07%	11.54%	11.57%	11.51%	11.57%	11.16%	11.09%

Efficient Use of Resources

Metric	Threshold / Target	External/Internal	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sept 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25
YTD variance from control total (£'k)	0	External	0	0	-26	-103	-9	-16	-17	-2	-1	-3000	-3000	-3000
Active Inappropriate OAPS at end of month	< 8 Q1, 5 Q2, 3 Q3 , 1 Q4	External	5	3	4	3	4	7	4	0	1	1	1	0

In addition to our 'Driver' Metrics, we report on a number of 'Tracker' metrics and follow a strict set of business rules which manage the reporting and escalation when performance is off target. Performance against both our 'Driver' and 'Tracker' metrics are available for the public to view as part of our published Trust Board papers and can be accessed via the Trust's website.

We also use benchmark information to inform our assessment of our services' efficiency and effectiveness compared to other providers. We undertake regular data quality audits and Information is also triangulated with data from other sources, such as Trust Board and Governor service visits, complaints and patient feedback to provide additional assurance on performance quality.

Financial Performance

The Trust's financial position is detailed in the Annual Statutory Accounts, which are part of this Annual Report. The Audit Committee on behalf of the Trust Board approved the full Audited Accounts on 18 June 2025 and the Auditor's opinion on the Financial Statements was unqualified.

The Trust delivered its financial plan for 2024-25 and ended the financial year reporting a surplus of £5.0m. After accounting for the impact of donations, non-operating fixed asset impairments and the re-measurement of PFI liabilities, the Trust has reported an adjusted surplus of £4.9m. A summary of our financial performance can be seen in the table overleaf. Our financial statements can be found in the Annual Accounts later in this report.

2024-25 Income and Expenditure	Actual £m	Plan £m	Variance £m
Operating Income	392.4	373.8	18.6
Elective Recovery	12.2	4.1	8.1
Total Income	**404.5**	**377.9**	**26.7**
Staff Costs	309.9	292.1	(17.8)
Non-Pay	68.3	61.1	(7.2)
PFI Lease	8.5	8.8	0.4
Net Interest	0.2	1.0	0.7
Depreciation	11.1	11.2	0.2
Impairments	0.3	0.0	(0.3)
Disposals	0.0	0.0	0.1
Remeasurement of PFI	1.3	2.0	0.7
PDC Dividend	0.0	0.0	0.0
Total Expenditure	399.6	376.3	(23.2)
Reported Surplus	**5.0**	**1.5**	**3.4**
Impairments and Donated Income	0.3	0.1	(0.3)
PFI Adjustment	-0.4	0.3	0.7
Adjusted Surplus	**4.9**	**1.9**	**3.8**

Our Trust's individual financial performance is now aggregated with that of our partners across the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System and collectively we are responsible for the delivery of the system's financial targets. This ensures that we continue to build a shared responsibility for the effective use of our collective resources as we aim to achieve financial balance across the system. The Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System reported a £15.5m deficit for 2024-25. This was in line with the revised target deficit set by NHS England for the system.

The Trust's revenues are predominantly generated from other NHS organisations, and we have generated income of £26.7m in excess of planned levels this year. This included a £18.1m funding adjustment for Employer's Pension contributions. Earlier in the year, the Trust received additional funding for the 2024-25 pay award which was higher than the percentage included in the plan. NHS England enabled Trusts to adjust their financial plans to take account of this. We have also benefited from a higher level of Elective Recovery Funding than was planned. Pay costs were £17.8m higher than planned, but again this was driven by the in-year Employer's Pension Adjustment.

Non-pay costs were higher than planned. Mental Health placement costs were higher than planned as pressure continued on our Mental Health inpatient services. However, costs were lower than in the previous year and in Quarter 4 we opened our new outsourced acute inpatient ward which has enabled us to reduce out of area and ad-hoc placements. We have also outsourced activity to other non-NHS providers to assist with waiting times and to achieve planned levels of activity.

Our level of capital expenditure must now be agreed with our system partners within an overall system allocation. We have continued to invest in technology, improving cyber security, enhancing and developing on-line services to patients and continuing to enable our workforce to work remotely. Our overall capital investment in technology was £5.0m this year. In addition to technology, we have continued to ensure our facilities are safe, of good quality and enable a positive service user experience.

This year we have invested £6.4m in our estate, including our new Place of Safety at Prospect Park Hospital, which is due to complete in 2025-26; an additional Dental Surgery at St Mark's Hospital; reconfiguration of space at Bath Road, Reading as part of our consolidation of sites in West Berkshire; and anti-ligature measures across our sites.

The Trust finished the year with a closing cash balance of £54m, which represents an increase of £1.4m compared with the previous year.

The Trust has no overseas operations.

Important Events Since Year End

There are no material events to report since 31 March 2025.

Better Payment Practice Code

The Trust aims to pay suppliers and providers of goods and services promptly and has a target of paying 95% of all invoices within 30 days of receipt. The Trust achieved the target in 2024-25 with performance as follows:

	Actual Number	Actual £'000
Non NHS		
Total bills paid in the year	28,149	83,579
Total bills paid within target	27,527	81,811
Percentage of bills paid within target	**97.8%**	**97.9%**
NHS		
Total bills paid in the year	835	7,501
Total bills paid within target	814	7,221
Percentage of bills paid within target	**97.5%**	**96.3%**
Total		
Total bills paid in the year	28,984	91,080
Total bills paid within target	28,341	89,032
Percentage of bills paid within target	**97.8%**	**97.8%**

2025-26 Financial Plans

We have prepared our financial plan for 2025-26 jointly with the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board, with specific contributions to community and mental health elements. This has included a system-wide alignment of the planning approach and peer review of plans. Our Trust Board approved the Trust's final financial plan 2025-26 for submission to NHS England at an extraordinary meeting on 20 March 2025.

We work closely with our partners across the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System to agree our annual proportion of the system capital allocation, and throughout the year our spend against this allocation is closely monitored and reported to system Chief Financial Officers, ensuring that in year variances to allocation are managed to ensure that the system fully utilised its allocation. We have agreed a capital plan as part of our financial plan submission to NHS England.

Health Inequalities

The Trust is making good progress on its Health Inequalities programme of work. We have an agreed Health Inequalities strategy in place and have committed to working with the Berkshire Voluntary, Community and Social Enterprise Sector (VCSE) in 2025 to co-produce the next version. The next version will include two additional priority areas of work developed with Reading ACRE (Alliance for Cohesion and Racial Equality) and Slough CVS (Council for Voluntary Services), supporting community engagement to identify with Reading and Slough communities, the potential Health Inequalities programme in each locality as part of our commitment to focussing the next round of Health Inequalities projects in areas of highest deprivation.

As part of Berkshire Healthcare's Health Inequalities strategy, we have had a focus on reducing the number of Black people detained under the Mental Health Act 1983. We committed to address the Trust's significant variation in detention rates across the Berkshire local authority areas and improve the overall detention rates for Black people. Our project aims to understand why this happens and find ways to make mental health care fairer for Black people.

In 2022, we reported to the Trust Board that nationally Black people were 4.5 times more likely to be detained under the Mental Health Act than a white person. In Berkshire, Black people were 3.07 times more likely to be detained under the Mental Health Act (MHA) than white people with significant variation across the Berkshire localities ranging from 1.07 times in Slough to 3 times in Windsor and Maidenhead from April 2020 to January 2023.

Two years on, we have researched the potential drivers, built partnerships with the Thames Valley Police, the local authority Approved Mental Health Professionals, completed community engagement work, gathered lived experiences and reviewed clinical notes. Since first reporting the figures of this health inequality, our data across Berkshire has shown a marked improvement and now a Black person in Berkshire is 2.3 times more likely to be detained under the Mental Health Act than a white person.

We understand the drivers of the inequity in the rates of detentions and are working with the NHS Race Health Observatory to independently review our work and help us build the actions for 2025/26 that will commit the Trust and partners to supporting.

We are working with many partners, including:

- Black people who have been detained and their carers
- Local communities and voluntary organisations – Alliance for Cohesion and Racial Equality (ACRE) Reading, Slough Council for Voluntary Services (CVS) and MIND Berkshire
- Health and Local Authority professionals – Approved Mental Health Professionals
- Thames Valley Police
- University of Reading, University of Southampton and Other NHS providers (South London and Maudsley NHS Foundation Trust, East London NHS Foundation Trust and Coventry and Warwickshire Partnership Trust)
- Race & Health Observatory and National Institute of Health and Care Research Applied Research Collaboration Oxford and Thames Valley (National Institute for Health and Care Research Applied Research Collaborations)

We have engaged with our Black community and thematic feedback is:

- **The Trust's Mental Health pathways and process** are contributing towards discriminatory practices which exclude Black people from equal access.
- **Carer/care givers expressed that they were not supported** by the Trust to access information and support for their loved one to aid their recovery, and maintain their own wellbeing
- Mental Health services were not designed to meet their **cultural needs**
- **Significant mistrust with Police & Professionals'** intentions and perceptions
- The Police have shared that they do not feel supported by the Trust in the **use of section 136 of the Mental Health Act** which grants police the power to detain individuals in a public place if they believe they are mentally disordered and need immediate care and will detain rather than seek alternatives
- **Approved Mental Health Professions detention process shows variation** in practice across Berkshire, which contributes to increased detention rates in some localities
- Trust data collected during the Project cycle shows that **Black people do not access Mental Health services at the same rate** as white people (per population)

- From the case review 70% (37/53) had **multiple inpatient admission under Section 2 of the Mental Health Act**
- Only 20% accessed Talking Therapies
- Recovery support was not provided, **86% of cohort did not receive Cognitive Behavioural Therapy for Psychosis (CBTp)** to aid their recovery.
- There is evidence from other NHS trusts (South London and Maudsley NHS Foundation Trust and Coventry and Warwickshire Partnership Trust) that **having Advanced Choice Documents in place reduces multiple admission** for Black people (person centered care)

We have an implementation plan in place for 2025/26 and are hosting a partnership conference on Mental Health Act Detentions with the NHS Race Health Observatory and Thames Valley Police on 1 April 2025.

Health Intelligence

Recognising the importance of Health intelligence in addressing health inequalities, we have been working collaboratively with our Business Intelligence team, clinicians and key stakeholders to co-design a Mental Health Act Tableau performance dashboard, further strengthening our Mental Health Act Detentions Data Analysis by:

- Having access to **live data**
- Providing a **consistent approach** - turning health intelligence into actionable data
- **Summary infographics** – readily available in various formats e.g., PDF, Power point and Excel
- **Identifying themes** by comparisons of rates of detention under the Mental Health Act, for different age groups, or ethnicities or genders, localities as derived from RiO (electronic patient record system)
- Resulting in **fewer data requests to the Business Intelligence** team
- Greater visibility for key stakeholders
- **Potential to act as long-term solution for Mental Health Act data requirements for reporting, tracking and monitoring.**

Quality Improvement approach to addressing health inequalities

In 2023/24 we implemented two Quality Improvement projects on health inequalities.

1) **Improving physical health outcomes for people with severe mental illness (SMI) in Reading**

Reading is an outlier for premature mortality due to cancer in adults with severe mental illness. Premature mortality across Berkshire for this cohort in 2019 was 79.93/100,000 population. In Reading it was 120.9/100,000 people, around 50% higher. This project focusses on ensuring cancer screening and lifestyle interventions are accessed by all patients with severe mental health illness receiving care from Reading Community

Mental Health Team to bring their life cancer mortality in line with the general population. This will continue into 2025 with specific countermeasures to increase knowledge and awareness of cancer symptoms and promote opportunities for, and importance of cancer screening, with information to support access.

2) Improving outcomes for culturally ethnically diverse clients in Talking Therapies

Based on the Positive Practice Guide, the NHS Data and the NHS principal of providing equitable services - the ethnicity of service users should reflect the population served in terms of the number of referrals and access to services.

Talking Therapies data showed this principle was not being met for Culturally and Ethnically Diverse clients across the service. The Talking Therapies team aim to improve outcomes for Culturally and Ethnically Diverse clients to be in-line with national targets. This project will continue in 2025 with countermeasures to increase the number of Asian/Asian British clients finishing a course of treatment and increasing 'reliable recovery' for Culturally and Ethnically Diverse clients.

Other projects

Physical health checks for people with severe mental illness

People with severe mental illness are at a greater risk of poor physical health and have a higher premature mortality than the general population, often dying 20 years sooner of preventable long-term conditions i.e., cardiovascular disease or cancers. We provide health checks for people with severe mental illness at clinics, home visits and community sites. We include a focus on smoking and tobacco dependence in the health check offer on the Trust's Health Bus at various community settings.

Reduction of smoking for people with severe mental illness

The smoking prevalence in adults with diagnosed long-term mental health conditions is more than twice that of the general population in Berkshire West (25.2% versus 10.9% respectively). We provide an in-house Tobacco dependency service at Prospect Park Hospital. All patients with severe mental illness are screened on arrival (target 90%) and referral is made to the Tobacco Dependence Unit. We have provided 'Very Brief Advice on Smoking' training to all front-line staff. Linked to the Quality Improvement metrics, a pilot scheme 'swap for stop' - vape starter kits alongside behavioral support - to help them quit the habit is to commence in Reading in quarter 1, 2025.

Social Value

We have an established workstream focussed on strengthening the Trust's contribution to social value. The Trust's contribution to social value falls within two areas – procurement and recruitment.

Social value is already considered as part of our procurement process, and the working group will look to support a consistent approach across the Trust.

The Recruitment and Selection Steering Group is currently mapping the recruitment and retention initiatives that fall under the 'social value' banner with a view to focussing attention on key areas and demographic groups.

The current strategy can be found here: health-inequalities-strategy-bh861.pdf and is overseen by the Health Inequalities Oversight Group chaired by the Deputy Chief Executive.

We are partners in the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board's Prevention, Population Health & Reducing Health Inequalities Group, the Berkshire Health Inequalities Group and the Frimley Health and Care Integrated Care System's Living Well Board.

Developing an Anti-Racism strategy

The Anti-Racism Strategy was developed due to persistent and unacceptable inequalities faced by our ethnically diverse staff and patients, as evidenced through data such as the Workforce Race Equality Standard and other well documented reports. We have taken an intentional and impactful approach to becoming an anti-racist organisation. It is important that our communities know that 'not being racist, is not enough' for us and that we all need to come together and confront racism and discrimination in all its forms.

Throughout the year, our strategy has led to significant actions, including reviewing disciplinary processes, launching the Prospect Park Hospital Advocacy for Racial Equality Team, engaging with the Equality staff networks, and initiating the Berkshire Healthcare Anti-racism in Healthcare CommUNITY Forum. Executive leadership has overseen progress, with all Executives leading on a different workstream as we acknowledge the need for more action.

In October 2023, the Patient Carer Race Equality Framework (known as PCREF) was launched. PCREF is NHS England's first ever anti-racism and accountability framework to tackle and eliminate the unacceptable racial inequalities in access, experience and outcomes faced by racialised and ethnically and culturally diverse communities and to significantly improve their trust and confidence in mental health services. It sets out the **legislative and regulatory context** for **advancing mental health equalities** and aims to assist mental health trusts and other mental health providers to comply with their obligations. It forms part of the wider planned legislative reforms of the Mental Health Act, which are being taken forward by the Government, as highlighted in the Government's white paper on Reforming the Mental Health Act.

Over the last year we have had a PCREF Task and Finish group overseeing the work we

have completed in assessing our current position against the PCREF national organisational competencies and have an action plan in place for 2025/26 which includes a clear focus on strengthening our approach to co-production and community engagement and creating an Equity Partnership Group to support community engagement in the work of the Trust.

Social, Community, Anti-Bribery and Human Rights Issues

The Trust Board conducts its business in an open and transparent way. We are committed to preventing bribery and combating fraud. To limit our exposure to bribery, we have in place a Standards of Business Conduct policy, a Freedom to Speak Up: Raising Concerns policy and our Duty of Candour and Being Open policy.

We hold a register of interests for directors, staff, and governors and ask staff not to accept gifts or hospitality that will compromise them or the Trust. We employ TIAA, our local Anit-Crime specialists who investigate, as appropriate, any allegations of fraud, bribery or corruption supported by our Counter Fraud policy.

As a public sector body, we are committed to fully meet our obligations under all aspects of the Human Rights Act 1998, Mental Health Capacity Act 2005 and the Equality Act 2010 and ensure we have supporting policies in place within the Trust including Mental Capacity Act and Deprivation of Liberty Safeguard policy, Section 132 Detained Patient's Rights policy and Equal Opportunities and Diversity policy. Trust policies are available to all staff and are routinely updated and reviewed.

Equality of Service Delivery

We have a Trust Board-approved Culture, Inclusion and Equity Framework which includes objectives for our workforce, patients and communities who use our services. We are clear about our responsibilities under the public sector equality duty, including:

- Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act
- Advance equality of opportunity between people who share a protected characteristic and those who do not
- Foster good relations between people who share a protected characteristic and those who do not

We have identified clear areas of focus for our patients and service users and our staff. More information is set out in the Equality, Diversity and Inclusion section of the Annual Report and in the Culture, Inclusion and Equity Framework, People Strategy and Health Inequalities Strategy (available on Trust's website).

We utilise our iWantGreatCare patient experience dashboard to support equality of service access, experience, and outcomes. The feedback survey includes up to seven core questions and demographic information, plus the existing Family Friends Test (FFT) questions. This enables us to consistently collect and compare anonymous patient experiences across all our services. This year we made further developments so that we can see the proportion of feedback for each protected characteristic.

Key performance indicators for all the work identified in the Culture, Inclusion and Equity Framework are monitored regularly via the Trust's Diversity Steering Group, Strategic People Group and reported periodically to the Trust Board.

Further progress is measured through standards and benchmarking work associated with the national NHS Staff Survey, Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES), Gender, Ethnicity and Disability Pay Gap reports which are published annually. We also participate in several benchmarking activities including the Stonewall Workplace Equality Index (WEI), the Neurodiversity Index, Disability Confident Accreditation, and Race Equality Matters Trailblazer.

Equality, Diversity and Inclusion (EDI)

This report outlines our compliance with the Equality Act 2010, Health & Social Care Act 2022, and NHS Standard Contract, detailing efforts to reduce inequalities for patients, the local population, and staff. We align with the NHS Equality Delivery System (EDS) and NHS England's Equality, diversity and inclusion Improvement Plan, which supports our Trust Strategy and is published on our website.

For 2025/26, we are embedding health inequality and anti-racism goals into our Trust's plans, focusing on improving data collection, addressing referral disparities, reducing missed appointments, increasing training access, and enhancing ethnic diversity in senior roles. Case studies and service insights will guide our actions.

Public Sector Equality Duty

The Trust must meet the Public Sector Equality Duty (PSED) under the Equality Act 2010. This means considering how our actions and decisions affect people with protected characteristics: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race and ethnicity, religion or belief, sex, and sexual orientation. We also consider the needs of Armed Forces personnel and veterans, parents, carers, those affected by homelessness, socioeconomic disadvantage, substance misuse, geographic barriers, looked-after children, students, and patients.

Equality Impact Assessment

To support the PSED, we have enhanced our approach to Equality Impact Assessments (EqIAs). The EqIA's help us review the impact of decisions on people with protected characteristics and vulnerable groups. We have simplified the process, and all new or revised policies, changes, projects, or transformations are reviewed for equality impact. We have developed supporting materials and planned learning sessions.

Our Culture, Inclusion and Equity Framework

This overarching framework guides the delivery of our People, Health Inequalities, Anti-racism, and Neurodiversity action plans. It sets out our principles and expectations for behaviour and culture, ensuring a unified approach to inclusion that supports a strong safety culture. An inclusive culture underpins all others—driving staff engagement and improving patient care. Our Goal: To create an inclusive and equitable culture where:

- All colleagues want to work here, can thrive, and feel a sense of belonging
- Our communities feel involved in their care
- The care we provide is culturally appropriate

Staff Networks
The Trust is proud to have five equality staff networks which are:

- **Armed Forces Network** - supports the Armed Forces Community.
- **Pride** – advocates for LGBTQIA+ equality.
- **Purple** - supports staff with disabilities and/or caring responsibilities.
- **Race Equality** – Promotes equality and wellbeing of global majority staff.
- **Women's Network** - Supports gender equality and accountability.

Gender

The Women's Staff Network
Launched in March 2024 alongside International Women's Day, the Women's Network supports all those who identify as women and their allies by creating a safe space to share experiences, raise awareness, and drive change.

Our aims:
- Champion women's contributions and support career development.
- Challenge bias and highlight barriers women face.
- Inspire and create an inclusive space for sharing and learning.

In our first year, we focused on hormone health, women in the workplace, and support for childcare, maternity, and working parents. We worked with other staff networks to promote intersectionality and reached wider audiences through events, panels, and webinars.

Key highlights:
- September 2024: "Women in the Workplace" event with 100+ attendees, guest speakers, and interactive sessions considering confidence, gender roles and mental load.
- March 2025: Hormone Health Conference with 150+ attendees, 20+ expert speakers, and wellbeing stalls.

We also hosted "Coffeeshop" sessions covering topics like maternity experiences, retirement, bladder health, childcare, menopause, and hormone health, as well as a panel on gender inequality and domestic abuse.

Achievements and Next Steps:
- Gained 288 members and expanded our reach through collaboration and inclusive events.
- Developed key platforms: intranet page, MS Teams group, email list, and shared resources.
- Year 1 goals:
    - Build a strong, inclusive network for women.
    - Broaden awareness and accessibility of our work.

- Collaborate with other staff networks to support women from diverse backgrounds.

Gender Pay Gap

In 2024–25, The Trust's median gender pay gap was 12.4%—a 0.85% decrease from the previous year. The mean gap rose slightly to 15.99%, up 0.45%. This shift reflects changes in workforce distribution, with fewer males in upper quartiles and more in lower ones, alongside a rise in females in upper quartiles.

To address the gap, we have introduced mid-year talent and career conversations to support more equitable progression, launched a Continuing Professional Development dashboard for data insights, and promoted leadership development for women and ethnically diverse colleagues in Agenda for Change pay Bands 5–8a. Gender pay gap reports have been shared and co-produced with staff networks, particularly the Women's Network, which held events on gender inequality, flexible working, health, and career progression.

We also continued to use an intersectional lens. In 2024–25, White males earned £4.64 more per hour than Black males (up £1.21 from 2023–24) and £5.17 more than Black females (up £0.92).

LGBTQIA+ Inclusion

Relaunch of the Pride staff network: Pride Month – 18th July 2024 - Half Day face to face event. All Trust staff interested in the network, allies and LGBTQI+ members were invited to celebrate Pride diversity. Guest speakers sharing their lived experiences of being part of the LGBTQIA+ community and the challenges they faced. Guest speakers covered a number of topics including:

- Lived Experience –Sharing experiences on Gay marriage, and same sex parenting.
- Lived Experience –Having a Transgender family member in an Asian family.
- Lived Experience –Being a Gay man in the Asian Community.

Spilling the Tea Podcast - Pride

The Pride Network Chair hosted a podcast series called Spilling the Tea, featuring interviews with external guests discussing key issues and hot topics within the LGBTQIA+ community. The four episodes share lived experiences, designed to be emotive and thought-provoking. Promoted through Pride Staff, inclusion webpages, and LGBTQ+ events, the podcast serves as a valuable learning resource for staff. With 15 completions so far, we aim to increase engagement by incorporating it into our 2025 communication and engagement plan, ensuring all staff feel supported and empowered.

LGBTQ+ History Month: Activism and Social Change

Hosted by our Equality, diversity and inclusion team with a guest from the Frimley Health and Care Integrated Care Board, Radio Pride covered activism and social change. It explained the LGBTQIA+ letters, the Pride flag's evolution, and key historical milestones. This inclusive event celebrated diversity and resilience in honour of LGBTQ+ History Month and fostered more compassion and understanding across the Trust. We explored intersectionality, real-life challenges, and the power of unity across staff networks to mark Pride Month.

International Day of Pronouns - 15th October 2024

We launched Pronoun Badges and invited all staff to take the Pride pledge, committing to using and respecting pronouns. The focus was on educating staff about the importance of pronouns, practicing gender-neutral language, and fostering a more inclusive environment. The goal was to create a world where everyone feels safe, valued, and respected for who they truly are.

Bracknell Forest Pride, and Reading Pride

We proudly took part in both Bracknell Forest Pride and the 21st annual Reading Pride, celebrating LGBTQIA+ communities and promoting inclusion with a variety of our teams providing health information and raising awareness of our services.

At Reading Pride, our volunteers supported a pop-up health space, engaging with the community and promoting the Trust as an inclusive employer. Our Sexual Health and Talking Therapies teams were present, and our health bus offered liver health checks throughout the day.

Transgender and Non-Binary

In response to Stonewall's recommendations, we enhanced our commitment to trans and non-binary inclusion by establishing a working group to improve patient experiences. Insights from the 'I Want Great Care' survey and Reading Pride emphasised disparities for trans patients, showing the need for further staff education.

We expanded training with nine e-learning modules and two webinars on allyship and inclusivity, equipping colleagues to support the community. On Transgender Day of Visibility, we celebrated trans and non-binary people through events and stories. The 'Ask Jake' online event, attended by 93 people, featured a trans NHS colleague sharing their experiences, and received 100% positive feedback.

Stonewall Workplace Equality Index (WEI)

We continue improving LGBTQIA+ inclusion in line with the Stonewall Workplace Equality Index. Preparing for our next submission in May 2025, we have enhanced our trans and non-binary staff training. We have expanded gender identity options in internal assessments and improved pronoun and name fields in patient systems.

Staff network engagement has remained strong. We are also co-developing a new regional Workplace Equality Index learning group with local partners across, reflecting our commitment to sector leadership and shared progress.

Disabilities, Mental Health, and Wellbeing

Staff Networks: Purple

The Purple Network supports staff with disabilities, mental and physical health issues, neurodivergence, and caring responsibilities.

Membership grew by 33% to 384 from 288. The network engages members through feedback to ensure activities reflect their needs. Ongoing initiatives include:

- **Purple Coffee House**: Monthly sessions for group discussions with guest speakers.
- **Friday Action**: Weekly posts on the Teams channel encouraging positive actions and discussion.

The network introduced new initiatives like the Through the Looking Glass peer support group for neurodivergent colleagues and Purple Wellbeing drop-in sessions (starting in April 2025) for informal support. The Working Carers Network collaborates with the Wellbeing team on bi-monthly sessions.

The Purple Network has partnered with the Equality, diversity and inclusion and Human Resources teams on several initiatives, including the Inclusion Passport, AccessAble, recruitment workshops, and reviewing the reasonable adjustment process.

Mental Health Act Detention Project

As mentioned in the Performance Report, as part of our Health Inequalities strategy, we are focused on reducing the disproportionate detention rates of Black people under the Mental Health Act 1983. Black people were 3.07 times more likely to be detained in Berkshire. We have partnered with Thames Valley Police, local Approved Mental Health Professionals, and community organisations like Alliance for Racial Cohesion (ACRE), Reading, Slough Council for Voluntary Service and MIND Berkshire to understand why. We have gathered lived experiences, reviewed clinical notes, and improved data. As a

result, the detention rate for Black people in Berkshire has improved to 2.3 times more likely than white people. We are continuing our work with the NHS Race Health Observatory to independently review our progress and shape our actions for 2025/26.

Neurodiversity Strategy

Our neurodiversity strategy emphasises accountability and sustained delivery. We set up a new group to oversee evaluations and improvements, including the neuro inclusion passport and reviewing the neurodiversity dashboard. Specific projects continue, based on feedback from surveys and peer support groups, to focus on further improvements.

Accessible information Standard (AIS)

We engage with services to ensure effective AIS implementation. The neuro-inclusion passport, introduced in partnership with the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board, has received positive feedback. We have rebranded our staff intranet (called Nexus) and marketing tools to improve accessibility. Two NHS-approved eLearning courses on AIS are available on our Nexus platform, enhancing staff skills in supporting individuals with communication needs. We are also developing a care passport to support inclusive patient experiences for neurodivergence, faith, and gender identity.

Patient Administration System – RiO (electronic patient record system)

Feedback indicated a need to improve data collection methods to address care inequalities. The eHealth Passport initiative within RiO consolidates digital patient data into one dashboard, streamlining access to key information. Currently in testing, we are refining the system based on feedback from patients, carers, and staff, aiming to launch in July 2025.

Reasonable Adjustments

We have simplified the reasonable adjustment process based on staff feedback. Changes include a new e-referral form, the Inclusion Passport, and updated intranet resources. These adjustments support employees with long-term disabilities or health conditions to perform effectively in the workplace.

Accessible books for staff

Our Library and Knowledge Service offers books and information in various formats through the Royal National Institute of Blind People (RNIB) Bookshare, supporting people with print disabilities, dyslexia, or those who are blind or partially sighted. RNIB Bookshare collaborates with over 1,100 publishers to provide an extensive and accessible collection of resources.

Interpretation and Translation

The Equality, diversity and inclusion team manages spoken and British Sign Language (BSL) interpretation contracts, improving service access. Training has increased

translation request fulfilment from 59% to 98% and simultaneously reduced the service cost. Services are offered in over 100 languages including Sign Language, ensuring equitable access to healthcare and complying with the Equality Act 2010 and Accessible Information Standard.

Carer Confident Accreditation

We achieved Carer Confident Level 2: Accomplished, demonstrating our commitment to supporting carers in the workplace. This accreditation reflects our efforts to help carers identify themselves, involve them in policy development, and offer practical support. We aim to progress to Level 3 Ambassador status. This certification is valid until 15 February 2027.

Disability Confident Accreditation

We were delighted to retain the highest level of Disability Confident status, achieving 'Leader' status for 2024/25. Our focus remains on enhancing best practices to support individuals with disabilities in accessing employment. Collaborations with various teams and partners ensure we maintain and improve our 'Leader' status.

Workplace Disability Equality Standard (WDES)

Over the last three years, we have seen improvements in WDES staff survey indicators, with increases between 1% and 12% across seven indicators. However, job application success rates for disabled colleagues are lower. Our neurodiversity and recruitment work aim to address this inequality. The full WRES report is published on our website annually in September.

NHS Veterans Aware Accreditation

We have been re-accredited by the Veterans Covenant Healthcare Alliance, recognising our commitment to providing high-quality healthcare and support to veterans and their families. This five-year accreditation demonstrates our efforts to enhance wellbeing, provide seamless care during transitions to civilian life, and offering timely, personalised services for the Armed Forces community.

2024/25 Armed Forces Network Highlights

The Armed Forces Network is thriving under its new Chairs. A new recruitment strategy partnership with Step into Health and the Armed Forces Guaranteed Interview Scheme has brought armed forces community members into both clinical and non-clinical roles, earning the Trust two NHS Employers awards at the House of Lords. Key successes include:

- Recruiting our first nurse through our Step into Health Veteran Recruitment programme
- Leading a large delegation of staff to the national World War Two

Commemoration event attended by King Charles.

- Hosted a Remembrance Event led by our Chaplain and Royal Navy Reservist, attracting over 300 staff members, governors, the Royal Navy and patients.
- Participated in NHS events in Parliament and beyond, raising our profile and commitment to the armed forces community at a national level.
- Becoming the first NHS trust to work directly with the Royal College of General Practitioners to improve veteran awareness across primary and secondary care throughout Berkshire, receiving national recognition.

The Network consistently expands through intersectionality and joint events with our other Equality staff networks, and with the Royal Berkshire colleagues during Armed Forces Week.

Race and Ethnicity

Staff Network: Race Equality Network (REN)

REN membership has grown by 30%, reaching 327 members, reflecting our diverse workforce and the network's efforts in improving engagement through outreach, collaboration, and feedback. REN has contributed to anti-racism initiatives, strategy development, and education. Key activities include:

- **South Asian Heritage Month**: Showcased South Asian culture at four Trust sites and engaged with the community at events like Rakshan Bandhan.
- **Black History Month** (October 2024): Hosted a well-attended event with the theme "Reclaiming Narratives," featuring speakers sharing personal experiences on Black history and culture.
- **Braver than Before Leadership Development Programme**: REN members signed up for leadership development, aimed at addressing leadership disparities.
- **Supporting Leadership Days and International Hires**: REN co-presented workshops on race equality and supported initiatives for international staff.
- **Joint Initiatives with our Women's Network**: Co-presented on allyship and menopause event and co-produced a domestic abuse session.
- Upcoming Initiatives: Includes a **Men's Health MOT**, revival of the **Village Voice** forum, and a **summer park event**.

Black History Month

We celebrated Black History Month with events themed "Reclaiming Narratives," including:

- **Inclusion on the Move**: Our Equalities, Diversion and Inclusion team and staff networks visited sites to gather staff pledges on unity against racism and pronoun use.

• **Action Over Apathy – The Role of Senior White Female Allyship in Anti-Racism**: A panel event with 213 attendees discussed the role of white female colleagues in supporting Black colleagues, promoting equity, and creating change.
• **Race Equality Network Event**: External and internal speakers shared experiences on Black culture and history, with music and African food.
• **Anti-Racism CommUNITY Forum Anniversary Event**: This event celebrated migrant healthcare workers and discussed racism strategies.

Partners from the Buckinghamshire, Oxfordshire and Berkshire West and Frimley Health and Care Integrated Care Systems also hosted workshops and discussions on race, racism, and allyship.

Initiative: Radio Windrush
We commemorated the arrival of the HMT Empire Windrush in the UK on June 22, 1948, recognising the significant contributions of the Windrush generation to the NHS. To celebrate, we hosted a Radio-style Windrush Podcast with a guest speaker in Health Inequalities. The session included music, relaxed conversation, and personal reflections. Key discussion topics included the power of diversity and unity, as well as issues such as gender, misogynoir, migration, nursing, antiracism, intersectionality, stereotypes, and advocacy.

Initiative: Multi – Faith Project
The Multi-Faith Project, developed with Buckinghamshire New University and the Anti-Racism CommUNITY Forum, seeks to tackle health inequalities and enhance community engagement by appreciating the role of faith. It offers co-created e-learning modules, ethical case studies, and community placements for mental health nursing students. The initiative also integrates faith-related questions into care passports to enhance patient experience.

Pay Gap Reporting
We published our second Ethnicity Pay Gap Report, revealing a median gap of 3.92%, and applied an intersectional lens examining both ethnicity and gender. Our work was featured as a case study in NHS Providers' national guide on tackling ethnicity pay gaps, and we presented this and our anti-racism journey at their national conference in Liverpool. Additionally, we engaged with the Cabinet Office to share our approach to developing ethnicity and disability pay gap reports. Notably, our 2024 disability pay gap was 0%.

Initiative: Race Equality Week, Every Action Counts
During Race Equality Week, we hosted "Every Action Counts," a session with 149 participants focusing on intersectionality, allyship, microaggressions, and calling in/out. Updates from the Race Equality Network and strategies for addressing racial harassment were shared, along with personal experiences. Resources to support staff dealing with racism from patients were also provided.

Initiative: Team meetings and away days

Positive Action for Finance, Contracting and Procurement Team
In a team session with 57 participants, we explored the distinction between positive action and positive discrimination, emphasising lawful strategies to promote workplace equality. Discussions addressed merit, bias, and inclusive job criteria, concluding with practical tips and resources to support equitable decision-making.

MSK Study Day: Recognising and addressing racism
The session explored workplace racism, microaggressions, and upstander strategies. It focused on handling patient racism with practical steps—setting boundaries, ensuring safety, and documenting incidents. A sample letter supported staff in addressing patient refusal. The goal: a safe, inclusive environment for all.

Anti-Racism Strategy
We are committed to being an anti-racist organisation, focusing on taking meaningful actions rather than simply avoiding racism. Our Anti-Racism Strategy addresses persistent inequalities faced by ethnically diverse staff and patients, informed by data such as the Workforce Race Equality Standard (WRES). We were delighted to be asked to present our anti-racism journey at a national NHS Providers conference in Liverpool.

Our key actions over the year have included:

- Revamping Equality Impact Assessments and integrating anti-racism into leadership development and coaching.
- Including racism discussions in staff appraisals and delivering training for Human Resources and investigating officers based on the Roger Kline *Too Hot to Handle* Report.
- Introducing guaranteed interviews for ethnically diverse candidates meeting essential criteria for senior roles.
- Celebrating the first anniversary of the Berkshire Healthcare Anti-Racism in Healthcare CommUNITY Forum to involve communities in our efforts.

Executive leadership has guided our progress, and we have ensured staff and patient feedback shapes our actions.

Race Equality Matters

We have earned the Race Equality Matters (REM) Silver Trailblazer Status, recognising our commitment to becoming an anti-racist organisation. This two-year award highlights our efforts in education, reporting, the anti-racism taskforce, and leadership-led initiatives. Awarded by an expert panel, it confirms the impact of our work with the Race Equality Network and diverse colleagues. REM, a non-profit formed after the 2020 Black Lives Matter movement, helps organisations globally implement solutions to race inequality.

Initiative: Action over apathy - The role of white female allyship in anti-racism

In a Black History Month webinar, a panel explored white female allyship in the workplace, using research focused on empowering senior white women as anti-racist allies. The discussion highlighted personal risks, the importance of honest conversations, and tools like journaling and affinity groups. The session emphasized consistent actions, reflection, and using platforms for meaningful change.

Grassroots Community Award

Karla Inniss, our Head of Inclusion, Organisational Development & Organisational Experience, was honoured by local grassroot communities in a special awards ceremony in October 2024.

This award recognised increased efforts to communicate with and involve racialised communities in the progress of our anti-racism approach. ACRE (Alliance for Cohesion and Racial Equality) hosted the awards and worked with partners to commend a range of wonderful local people achieving strides in improving the lives of people that live in and around Reading.

Karla said, “I'm so proud of the local work that is done, and I'm humbled to be recognised for being a small part of our wonderfully diverse community, who together, achieve life changing differences for local people.”

Initiative: Celebrating 1 year of our Anti-Racism CommUNITY forum

Launched in October 2023, the CommUNITY Forum meets bi-monthly to discuss topics like multi-faith education, mental health, the Patient Carer Race Equality Framework, and more.

The Anti-Racism Community Forum, organised by Berkshire Frimley Health Trust and presented by Karla Inniss, Head of Inclusion, OD & Organisational Experience, brought together over 65 NHS and community partners from across Berkshire, to explore ways to make health services more accessible and inclusive for our diverse and faith-based communities.

It has fostered inclusive, anti-racist discussions and provided a platform for sharing ideas and concerns.

To mark its first year, community members gathered for project updates, a Theatre Forum video idea session, an 'art of wellbeing' workshop, and a panel on community activism and female Muslim identity.

The event ended with plans for 2025/26 shared by the Deputy Chief Executive, Alex Gild.

Initiative: Holding Space to Talk About Race

Following our 'Diversify Your Bookshelf' initiative, we have launched quarterly "Holding Space to Talk About Race" sessions. Each will feature a short podcast on recent resources linked to anti-racism topics like recruitment, patient access, and policy, followed by an open forum for reflection and discussion. The goal is to provide an accessible space for colleagues to gain confidence in talking about race.

Initiative: Gypsy, Roma, Traveller Health Visiting

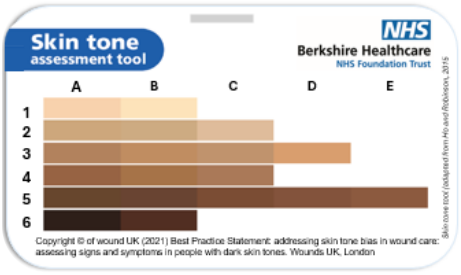
Our Health Visiting team addresses health inequalities by using a health bus to reach settled Traveller communities, particularly at Paices Hill in West Berkshire.

The team supports families with young children, offering play activities, dietary and dental guidance, and promoting immunisation.

They also make referrals for needs like autism assessments and coordinate with schools and GPs. Collaborating with partners like the Domestic Abuse Coordinator, the team's skills are enhanced by training from the Margaret Clitherow Trust.

The health bus schedule is expanding to new locations, including Four Houses Corner and Wokingham.

Initiative: Skin Tone Bias Assessment Tool



The Skin Tone Bias Tool addresses racial disparities in healthcare assessments, helping clinicians better assess wound care on Black and Brown skin—an area often overlooked in medical training.

Developed by a consultant nurse, it supports informed clinical decisions and reduces misdiagnosis or treatment delays based on skin tone. The tool will be rolled out this year with education, guidance, and assessment.

Patient and Carer Race Equality Framework (PCREF)

Launched in October 2023, PCREF is NHS England's first anti-racism framework to address racial inequalities in mental health services, improving access, experience, and outcomes for ethnically diverse communities. It helps mental health providers meet obligations and aligns with Mental Health Act reforms.

A PCREF Task Group has developed a 2025/26 action plan focusing on co-production, community engagement, and creating an Equity Partnership Group for outreach.

Workplace Race Equality Standard (WRES)

Over the past 3 years, we have seen a 2-10% improvement in WRES survey indicators for our ethnically diverse colleagues. While our scores are above average, there is more to be done. We are also examining data on job application success rates, which are currently lower for diverse staff. Addressing this is a key focus in our People Strategy, supported by anti-racism and recruitment improvement initiatives. WRES reports are published annually on our website.

Inclusion Learning and development

We deliver regular blended learning, with strong feedback from Equalities, Inclusion and Diversity induction and Conscious Inclusion sessions. In the last 8 months, we have enhanced content based on feedback and facilitator development to boost engagement both online and in person. Cultural Intelligence Training has been delivered system-wide via the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System, involving our Trust.

Our Manager Support Network provides recorded sessions on topics like Neurodiversity, the Sexual Safety Charter, Domestic Abuse Charter, the Purple Network, and our People and Culture Strategy. We have also added webinars and podcasts to our online resources, covering white female allyship, positive action versus discrimination, LGBTQ+ topics, and reasonable adjustments awareness.

All NHS organisations, including Berkshire Healthcare, require staff to complete mandatory Equality, diversity and inclusion training in accordance with the UK Core Skills Framework. This training must be updated every 3 years. As of March 2025, our workforce compliance with this requirement is just over 97%.

Accessibility in Digital skills

We are enhancing digital accessibility for staff with disabilities and neurodiverse needs. Partnering with our Information Management and Technology (IMT) function, we are auditing applications to maximise the use of built-in accessibility features.

OpenDyslexic font is now available to support staff with dyslexia. Following positive feedback from a mini module with 85 participants, our Digital Skills Training team will launch a full course on accessibility tools in Microsoft Office—covering Dictate, Immersive Reader, Focus, and Live Captions—to promote inclusion and well-being.

The Frimley Mirror Board

We supported the Frimley Health and Care Integrated Care Board, with the launch of their 'Mirror Board' initiative, designed to develop a diverse leadership pipeline and bring fresh perspectives to decision-making. Members, recruited from various sectors, represent diverse views and protected groups.

Over 18 months, they have engaged in key strategies on system planning, finance, and governance, receiving mentoring, cultural intelligence training, and Board business learning. The programme offers executive-level experience while promoting diversity and influencing decisions across the Frimley system, including our Trust.

Our Workforce Data

We use benchmarking tools to align with best practices and drive continuous improvement in staff and patient outcomes.

Equality, diversity and inclusion Dashboard

We have created an Equality, diversity and inclusion dashboard in Tableau to support race equality action planning, tracking data on contract type, work patterns, retention, turnover, and sickness. Future updates will include recruitment, temporary staff, and training data. Health inequality and patient experience dashboards are also available.

Improving Staff Equality Monitoring Data

A project to increase disability declaration rates within Medical Staffing has shown good progress, particularly among Resident Doctors. Efforts include promoting data completion during induction, through staff networks, and at educational events. Senior leaders have also encouraged Board-level participation, resulting in improved data sharing and a stronger sense of safety and belonging for all staff. We now have one of the highest levels of declaration for an NHS trust.

Table 1. Colleagues not sharing equality information on the Electronic Staff Record System (ESR)

Unknown/Not Stated	2025	2024	Improvement in 24/25
Age	0%	0%	0
Gender	0%	0%	0
Ethnicity	2.1%	2.3%	+0.2
Disability	6.4%	7.5%	+1.1
Religion	13.4%	14.7%	+1.3
Sexual Orientation	8.4%	9.5%	+1.1
Total Data Opportunities	33018	31314	+1,704
Not Stated	1670	1779	+109
Data Quality	95.0%	94.3%	+0.7

Table 2 - Trust's workforce by protected characteristics last 12 months.

	March 2022		March 2023		March 2024		March 2025	
	%	Staff	%	Staff	%	Staff	%	Staff
Total		*(4,780)*		*(4,968*		*(5,219)*		*(5,503)*
Age								
16 – 25 years	5.9%	283	6.3%	311	5.7%	300	5.8%	317
26 – 35 years	22.4%	1071	22.0%	1,093	22.7%	1187	22.9%	1260
36 – 45 years	25.7%	1,228	26.2%	1,300	25.7%	1343	25.7%	1415
46 – 55 years	27.2%	1,298	26.6%	1,320	25.6%	1335	25.8%	1419
56 – 65 years	16.7%	797	16.8%	834	17.8%	929	17.2%	948
66 plus years	2.2%	103	2.2%	110	2.4%	125	2.6%	144
Ethnicity								
White	69.4%	3318	68.8%	3420	67.6%	3530	65.1%	3581
Mixed	2.8%	134	2.9%	144	3.0%	158	3.0%	163
Asian	12.4%	591	13.8%	688	14.1%	738	15.5%	853
Black	10.1%	484	10.0%	495	11.2%	584	12.6%	693
'Other' Ethnic Group	2.2%	103	1.7%	84	1.6%	85	1.7%	95
Not specified	3.1%	150	2.8%	137	2.4%	124	2.1%	118
Gender								
Women	83.4%	3,986	83.3%	4,136	83.0%	4332	82.8%	4555
Men	16.6%	794	16.7%	832	17.0%	887	17.2%	948
Not specified	0	0	0	0	0	0	0	0
Disability								
Disabled staff	5.3%	255	6.4%	318	7.2%	378	8.7%	477
Not specified	9.1%	437	8.2%	411	7.5%	389	6.7%	367
Religion								
Christian	48.2%	2,302	47.3%	2,351	47.2%	2,464	46.8%	2576
Atheist	15.9%	758	16.7%	831	17.5%	911	17.8%	981
Islam	4.5%	214	4.6%	229	4.8%	248	5.7%	311
Hindu	3.4%	164	3.6%	180	3.7%	195	4.1%	228
Other	12.0%	574	11.9%	591	12.1%	632	12.2%	671
Not Stated	16.1%	768	15.8%	786	14.7%	769	13.4%	736
Sexual Orientation								
LGBQ+	3.3%	158	3.6%	178	4.1%	212	4.2%	230
Heterosexual	85.8%	4,009	86.0%	4,273	86.4%	4,509	87.4%	4811
Not Stated	11.2%	523	10.4%	517	9.5%	498	8.4%	462

Key highlights:

- 83% women and 17% men in our workforce.
- 65.1% white, 32.8% ethnically diverse and 2.1% not specified their ethnicity.
- 8.7% declared disabled, 6.7% not specified.
- 4.2% are LGBQ+, 87.4% are heterosexual and 8.4% have not shared.
- 14% of Agenda for Change Pay Band 8c+ senior managers are ethnically diverse.

Table 3. Senior Managers / Leaders (as of March 2025)

	Gender				Ethnicity					
	Male	No.	Female	No.	White	No.	Ethnic. diverse	No.	Undisc.	No.
Non Executive Board (7)	42.9%	3	57.1%	4	71.4%	5	28.6%	2	0.0%	0
Exec. Board (7)	71.4%	5	28.6%	2	57.1%	4	42.9%	3	0.0%	0
Directors (Locality, Clinical and other)	14.3%	2	85.7%	12	85.7%	12	14.3%	2	0.0%	0
Heads of Service	17.7%	3	82.4%	14	70.6%	12	29.4%	5	0.0%	0
Senior Managers (8c and above)	26.7%	27	73.3%	74	85.2%	86	11.9%	12	2.97%	3
BHFT staff (total headcount)	17.2%	948	82.8%	4555	65.1%	3581	32.8%	1804	2.14%	118

Emergency Preparedness, Resilience and Response

In line with its statutory obligations under the Civil Contingencies Act 2004, the Trust has arrangements in place for EPRR (Emergency Preparedness, Resilience and Response). We undertake emergency planning activities in collaboration with healthcare partners, local authorities and other emergency services. This work is undertaken through participation in regional and local forums such as the Thames Valley Local Health Resilience Partnership and the Berkshire Resilience Group.

The development and improvement of the Trust's incident response arrangements is overseen by the EPRR Governance Group. This Group reports to the Executive Non-Clinical Risk Management Committee which is chaired by the Chief Financial Officer.

Training

A Training Needs Analysis identifies the EPRR training needs for roles at various levels across the Trust. Training delivered in 2024-25 included:

- **Strategic and Tactical Command** – scheduled and ad hoc training for on-call operational and executive directors.
- **Lockdown** (delivered by the Risk Services Team)

Exercising and testing

Participation in exercises is an important part of training and learning. During 2024-25 several exercises were delivered; in addition, incidents and events throughout the year have provided further opportunities for testing business continuity and other plans. Some examples include:

- **Exercise Toucan** (23 May 2024) – national exercise to test incident notification processes at national, regional and Integrated Care Board levels.
- **Exercise Spider** (June 2024) – local multi-agency exercise to test cyber incident response.
- **Live incident** (June-July 2024) – industrial action by BMA resident doctors
- **Exercise Bright Spark** (July 2024) – internal exercise to test whole site power outage at Hillcroft House

- **Live incident** (July 2024) – Crowdstrike IT outage - global issue affecting multiple Microsoft applications.
- **Exercise Holler** (August 2024) – Integrated Care Board area exercise to test incident notification cascades and processes.
- **Exercise Alder** (September 2024) – national/regional command post exercise to test operational facilities and processes during concurrent incidents.
- **Exercise:** Jubilee ward (December 2024) – Internal tabletop/walkthrough of evacuation routes and shelter options

Post-incident debrief outcomes (lessons identified and shared learning) are reported to the EPRR Governance Group and cascaded via senior managers.

Assurance

All NHS organisations and providers of NHS-funded care in England are assessed annually against the NHS Core Standards for Emergency Preparedness, Resilience and Response (published by NHS England). Each organisation designates an Accountable Emergency Officer who is responsible for making sure these standards are met; the Accountable Emergency Officer for the Trust is the Chief Operating Officer.

The assurance process requires provider organisations to undertake a self-assessment and rate their compliance against those core standards which are relevant to their organisation type. The overall EPRR assurance rating is based on the percentage of core standards the organisation assesses itself as being 'fully compliant' with; this compliance rating is subject to scrutiny and ratification by the Integrated Care Board, as the lead commissioning body. Once ratified, provider organisations are required to share this information via a public Trust Board meeting and also to publish it in their Annual Report.

For assurance purposes in 2024-25, in November 2024, the Trust was assessed as **substantially compliant** overall (fully compliant with 54 of the 58 core standards applicable to community and mental health Trusts). Work is ongoing to address the four non-compliant standards.

NHS England - EPRR Assurance Compliance Levels

To support a standardised approach to assessing an organisation's overall preparedness rating, NHS England has set the following criteria:

Compliance level	Evaluation and Testing Conclusion
Fully compliant	The organisation is 100% compliant with all core standards they are expected to achieve. The organisation's Board has agreed with this position

Compliance level	Evaluation and Testing Conclusion
	statement.
Substantial compliance	The organisation is 89-99% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Partial compliance	The organisation is 77-88% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Non-compliant	The organisation compliant with 76% or less of the core standards the organisation is expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months. The action plans will be monitored on a quarterly basis to demonstrate progress towards compliance.

Looking forward for 2025-26

The EPRR work plan for the year ahead includes:

- **Evacuation and shelter plans** – plan to be in place for all inpatient sites; carry out exercises to test plans.
- **Business Continuity Plans** - All Services to have an in-date Business Continuity Plan uploaded in line with the Trust structure; critical services to have exercised plans to test validity.
- **Continue to participate in local/regional exercises**
- **Development of an EPRR Apprenticeship programme**; supports succession planning and collaboration with a university.
- **Assurance** - To support annual assurance process to assess Trust compliance against NHS England core standards for EPRR.

The EPRR team will continue 'horizon scanning' and working to support the Trust in its anticipation of, and response to, events and incidents which might affect delivery of essential services.

Sustainability and Climate Change

Over the past year, Berkshire Healthcare NHS Foundation Trust has made steady progress in integrating sustainability into its operations, strengthening its approach and building momentum towards long-term environmental goals. The Trust's sustainability programme reflects a broad and holistic approach, aligning with NHS England's expectations for NHS Trusts and Integrated Care Systems to deliver a Net Zero Carbon NHS.

Decarbonising a fragmented and ageing estate remains a significant challenge. Access to external funding, including the government's Public Sector Decarbonisation grants, is often complex and highly competitive. Where external funding is unavailable, the Trust continues to prioritise decarbonisation initiatives within its existing operational capital budget. Targeted investment in decarbonisation, such as on-site renewable energy generation, can generate meaningful cost savings, demonstrating that sustainability is not only an environmental imperative but also a financial opportunity.
This report provides an update on the Trust's progress towards its sustainability objectives, as set out in the Green Plan. It also details the Trust's broader commitments, including sustainable procurement strategies, and collaborative efforts with our partners, all of which contribute to achieving net zero by 2040.

Task force on climate-related disclosures
NHS England's NHS foundation Trust Annual Reporting Manual 2024-25 has adopted a phased approach to incorporating the TCFD recommended disclosures as part of sustainability annual reporting requirements for NHS bodies, stemming from HM Treasury's TCFD aligned disclosure guidance for public sector annual reports. TCFD recommended disclosures as interpreted and adapted for the public sector by the HM Treasury TCFD aligned disclosure application guidance, will be implemented in sustainability reporting requirements on a phased basis up to the 2025/26 financial year. Local NHS bodies are not required to disclose scopes 1, 2 and 3 greenhouse gas emissions under TCFD requirements as these are computed nationally by NHS England. The phased approach incorporates the disclosure requirements of the governance, risk management and metrics and targets pillars for 2024/25. These disclosures are provided below and the Trust's approach to risk management is outlined in the Annual Governance Statement (included in the Annual Accounts of the Report).

Governance
Our Chief Financial Officer is the Board-level Executive responsible for the Trust's net zero and sustainability agenda. The Trust's Green Plan was endorsed by the Trust Board and published in 2022 and will be updated this financial year. This document will set out the key actions the Trust plans to undertake in achieving our net zero ambitions.

The Green Group, chaired by the Chief Financial Officer, agrees and monitors all sustainability activities across the Trust that contribute to the delivery of the Trust's

Green Plan. This group also considers risks and opportunities relating to climate change as and when they arise, including reviewing external funding opportunities.

The Green Group reports to the Business, Finance and Strategy Executive Committee, which is chaired by the Chief Executive. Progress against the Green Plan is reported quarterly to this meeting. The minutes from this meeting are reviewed in the Finance, Investment and Performance Board sub-committee.

The Sustainability Manager reports on the Green Plan's progress bi-annually to the Trust Board, updating how we are meeting our reporting requirements as specified by NHS England and our local Integrated Care Boards.

Management's role in assessing and managing climate-related issues

We continue to embed the consideration of sustainability within our internal processes. Environmental impact assessments are now incorporated into all capital business cases and sustainability is a key criterion in the selection and development of new properties within our estate. All major projects proposed to the Programme Management Office are also reviewed for environmental sustainability and used for project prioritisation.

Risk management pillar

Our Board Assurance Framework now includes a risk around environmental sustainability. Our on-going mitigations against that risk are reviewed at our Business, Finance and Strategy Executive Committee, Finance, Investment and Performance Board sub-committee and Audit Committee.

To reduce risks of service or operational disruption due to the impacts of climate change or severe weather, our Trust has developed an adaptation plan using the Local Climate Change Adaptation Tool (LCAT) and information gathered from a climate change adaptation scoping exercise carried out at the Trust. This identified six action areas for adaptation planning and delivery, spanning governance, estate, services, procurement, finance and waste.

Metrics and target pillar

We monitor and report our direct carbon emissions, covering Scopes 1, 2 and 3 (excluding the NHS Footprint Plus), in our Annual Report. Our emissions are calculated using the Greenhouse Gas Protocol and are presented as $CO2_e$.

In 2023, we refreshed our strategic ambitions including key performance targets. As part of this, we set a strategic goal of achieving a 13% annual reduction in CO_2 emissions, with progress monitored quarterly by the Trust Board. This target is reviewed annually and adjusted as required, based on projected reductions and achievements from the previous year.

Highlights from 2024-5

- **Expanding Renewable Energy** – Solar panels have been installed at Church Hill House and Erlegh House, saving over 17 tonnes of CO_2 – the equivalent of over 1,000 trees. This is part of an ongoing programme, with three further sites identified for installation this year and a proposal in development for a major solar farm at one of our hospitals.
- **Decarbonising Our Estate** – Work has begun on a major decarbonisation project at West Berkshire Community Hospital, supported by £2.6 million in government grant funding. The project will replace fossil fuel heating with clean air source heat pumps and is due for completion in 2026.
- **Greener Transport** – The Trust's Estates fleet is now fully electric, with all eight light commercial vehicles converted to zero-emission electric vehicles, permanently reducing our travel emissions.
- **Sustainable Travel Planning** – A comprehensive travel and transport review, commissioned with the Energy Saving Trust, is laying the groundwork for our upcoming Travel and Transport Strategy, which will support our commitment to achieving net zero travel emissions.
- **Cleaner Air for Healthier Communities** – The Trust has developed and approved a new Clean Air Plan to reduce air pollution, improve air quality around our sites, and support staff and patient health through cleaner environments.
- **Reducing Waste, Cutting Carbon** – A detailed waste audit has been completed, forming the basis of a new Waste Strategy. This strategy focuses on improving waste segregation to reduce emissions associated with incorrect disposal into high-carbon waste streams.

Green Plan refresh

Berkshire Healthcare NHS Foundation Trust is updating its Green Plan in line with the latest NHS England statutory guidance, ensuring our approach remains ambitious, evidence-based, and tailored to our role as a community and mental health trust. This refresh builds on the progress made under our previous three-year strategy, strengthening our commitment to delivering high-quality, sustainable healthcare while reducing our environmental impact.

By aligning with national priorities and focusing on the specific needs of our services, the updated Green Plan will help us embed sustainability more deeply into our operations and improve outcomes for both people and the planet.

The new three-year Green Plan will outline nine focus areas:

- workforce and leadership
- net zero clinical transformation
- digital transformation
- medicines

- travel and transport
- estates and facilities
- supply chain and procurement
- food and nutrition
- adaptation

As our largest sources of emissions, decarbonising our estate and travel to support net zero commitments will remain a priority for our Trust, alongside key enablers such as digitisation, staff education, and engagement. Medicines, as well as food and nutrition, will be lower-priority areas for our Green Plan due to the nature of our Trust, which has limited inpatient facilities, and a different service focus compared to acute hospital settings. The Plan will be published in autumn 2025.

Our Carbon Footprint

Since our pre-COVID baseline year (2018/19), our Trust has reduced its carbon footprint by approximately 16.7%. Our Trust's direct carbon footprint for the 2024/25 financial year is 4945 tonnes of carbon dioxide equivalent (CO_2e), down from 4,981 tonnes the previous year (0.7% decrease, see Figure 1 and Table 1). This may be in part due to a change in the size of our estate, as the amount of greenhouse gases we emit per square metre has risen slightly (from 77 kilos CO_2e per square meter to 80). While electricity consumption has risen slightly at our sites, gas has decreased. Fleet and business mileage has risen by around 200,000 miles since last year, possibly due to an increase in service delivery, but more of these miles have been driven by zero emission vehicles. See Figures 2 and 3 for a breakdown of emissions by scope.

		2023/24						2024/25					
		BHFT-managed sites only			All sites (BHFT+NHSPS)			BHFT-managed sites only			All sites (BHFT + NHSPS)		
		Units	Tonnes CO2e	Cost	Units	Tonnes CO2e	Cost	Units	Tonnes CO2e	Cost	Units	Tonnes CO2e	Cost
Scope 1	**Gas**	7,145,488 kWh	1307	£348,515	11,345,878 kWh	2076	£755,636	7580681 kWh	1387	£425,158	10512663 kWh	1923	£681,546
	Transport	116,857 miles	28	£15,911	116,857 miles	28	£15,911	98,983 miles	21	£13,449	98,983 miles	21	£13,449
Scope 2	**Electricity**	4,456,139 kWh	923	£1,146,898	5,964,749 kWh	1235	£1,554,019	4,783,165 kWh	990	£1,290,966	6,246,460 kWh	1293	£1,690,146
Scope 3	**Utilities: electricity**	4,456,139 kWh	302		5964749 kWh	407		4783165 kWh	326		6246460 kWh	426	
	Water	39,719 m^3	13	£126,009	57,471 m^3	19.47	£147,438	38,885 m^3	13	£140,996	58938 m^3	19.9	£240,251
	Gas	7,145,488 kWh	215		11,345,878 kWh	343		7,580,681 kWh	229		10,512,663 kWh	317.6	
	Total utilities		531			769			568.3			771	
	Transport (grey fleet)	2,439,643 miles	801	£1,408,271	2,439,643 miles	801	£1,408,271	2,749,918 miles	867	£1,530,958	2,749,918 miles	867	£1,530,958
	Waste: General	231 tonnes	4.9	£20,121	382.6 tonnes	8.1	£50,771	228.8 tonnes	4.9	£25,962	426.5 tonnes	9.1	£62,696
	Recycling	72 tonnes	2	£9,381	111 tonnes	2	£21,246	67 tonnes	1.43	£17,215	144 tonnes	3	£36,119
	Food	17.1 tonnes	0.2	£554	17.9 tonnes	0.2	£1,455	17.5 tonnes	0.2	£1,109	22.4 tonnes	0.2	£1,304
	Clinical	109.1 tonnes	41.5	£30,125	165 tonnes	59.29	£54,500	97.7 tonnes	36	£40,547	178 tonnes	63	£86,513
	WEEE/other	3.2 tonnes	0.07	£682	13.8 tonnes	0.3	£1,455	6.2 tonnes	0.13	£5,420	15.8 tonnes	0.3	£6,070
	Confidential	32.5 tonnes	0.7	£4,980	77.9 tonnes	1.6	£11,922	38.3 tonnes	0.8	£3,655	76.9 tonnes	1.6	£9,678
	Total waste	462 tonnes	49	£75,883	768 tonnes	72	£155,997	456 tonnes	44	£67,946	864 tonnes	77	£202,380
Total			3638	£3,459,408		4981	£4,652,423		3878	£3,495,436		4945	£4,358,729

Table 1: Berkshire Healthcare's utility, waste, and transport footprint, alongside its associated carbon emissions, for 2024/25, and 2023/24 for comparison. For reporting, Berkshire Healthcare-managed sites include its two PFI hospitals, West Berkshire Community Hospital, and Prospect Park Hospital. All sites include those managed by NHS Property Services.

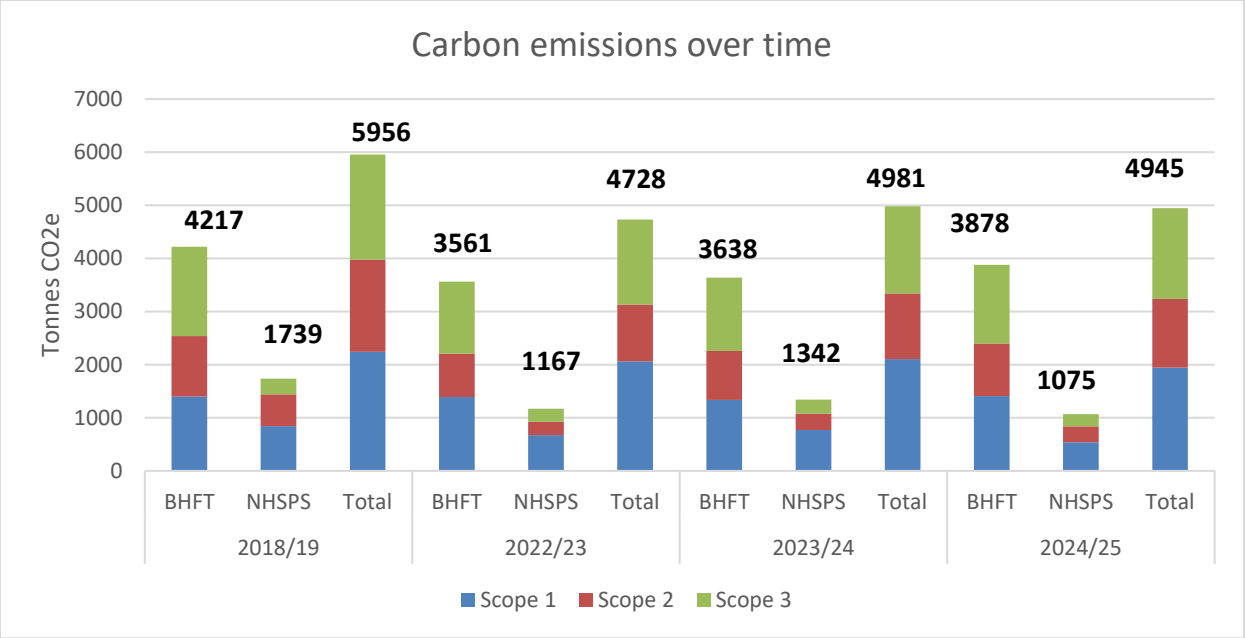


Figure 1: *Berkshire Healthcare's carbon emissions (CO2e) over time, broken down by Trust-managed sites and NHS Property Services-managed sites, and all sites (Total). 2020/21 and 2021/22 are not shown due to these being COVID-19 years and therefore unrepresentative.*

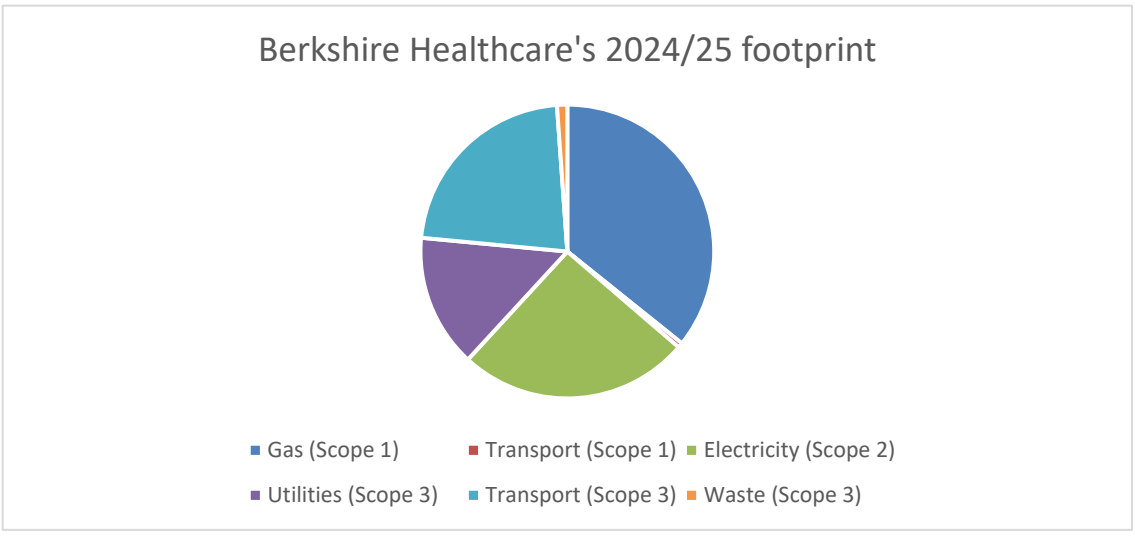


Figure 2: Berkshire Healthcare's carbon emissions in 2024/25 broken down by scope.

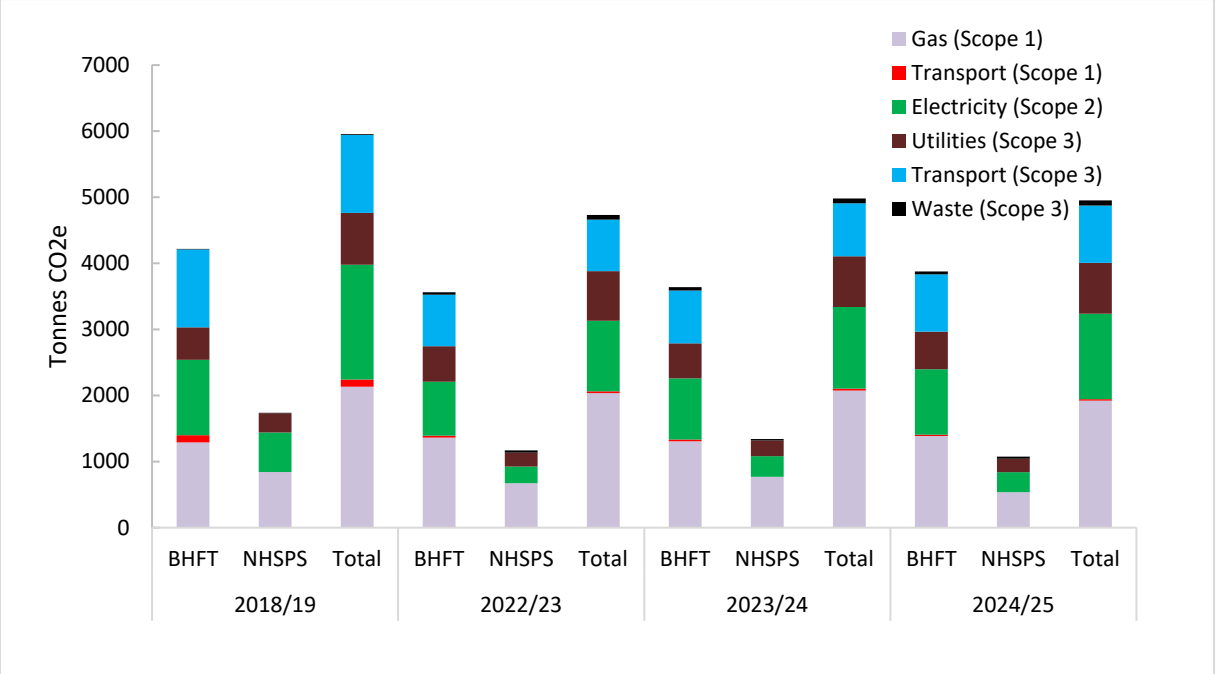


Figure 3: Berkshire Healthcare's emissions by scope over time, broken down by Trust-managed sites and NHS Property Services-managed sites, and all sites (Total). Transport emissions are all reported under Berkshire Healthcare managed site emissions. 2020/21 and 2021/22 are not shown due to these being COVID-19 years and therefore unrepresentative.

The Trust has taken several significant measures to assist in the reduction of its carbon footprint this year, including:

- Installation of solar panels at two sites
- Commencement of a major decarbonisation project at one of our hospital sites, switching from gas heating to heat pumps
- Completion of decarbonisation plans at all priority sites (i.e. those directly managed by the Trust and not NHS Property Services or a PFI, and those either owned or with a long lease)
- Electrification of all estates fleet vehicles
- Incandescent bulbs replaced with LED lighting across all Berkshire Healthcare-managed sites
- Our overarching ambition to be net zero by 2040, with an 80% reduction (compared to 1990) by 2028-2032, is still considered achievable. We have several carbon cutting initiatives in the pipeline, alongside early exploration of other key programmes, which have the potential to substantially reduce our emissions over the next five years and would therefore mean we reach our target. These include:
- Achieving a minimum of 10% carbon reduction from implementing recommendations from our completed decarbonisation plans and energy audits
- Implementation of key solar proposals, including a major solar farm

As demonstrated in Figure 4, our current emissions trend leaves a gap of 486 tonnes by

2030. Our Trust would need to reduce our emissions by a minimum of 7.2% a year to achieve the interim 80% reduction target by 2030. However, due to the trends seen over the past two years, this is likely to increase.

If key proposed projects outlined above are implemented, we would meet or possibly exceed an 80% reduction by 2030. Decarbonising our largest emissions source in our estate, Prospect Park Hospital, which has 28 end-of-life (over 10 years old) gas boilers, is also critical.

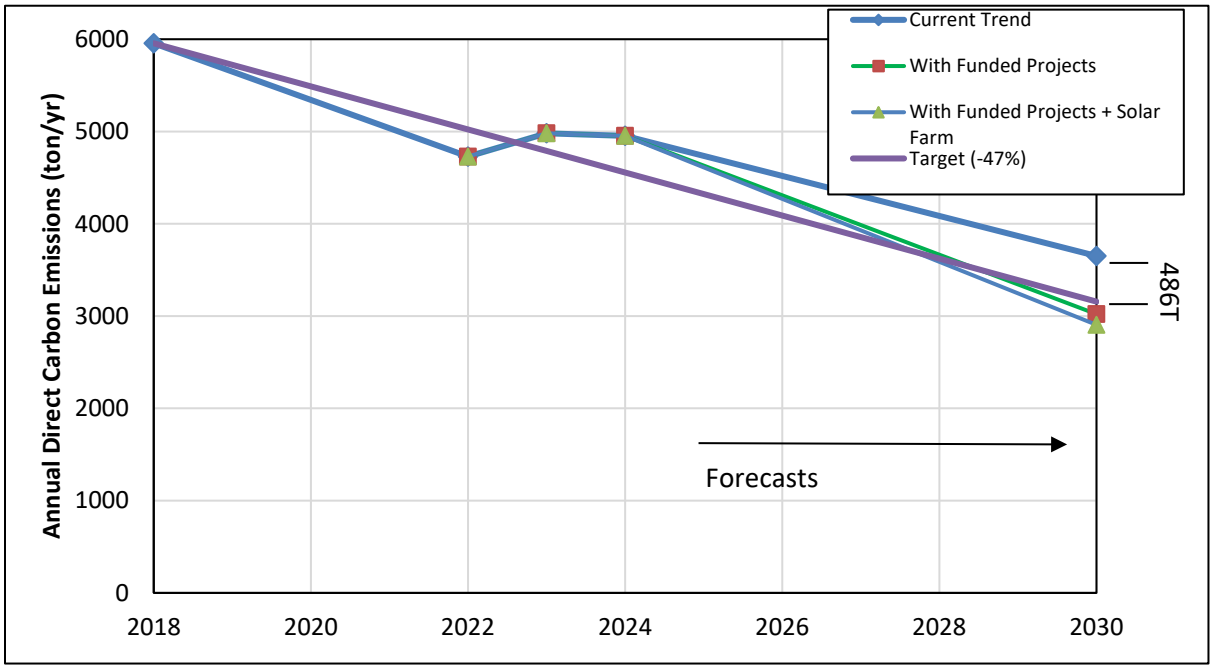


Figure 4: current trends in Berkshire Healthcare's carbon emissions, and projections based on two different scenarios. 'Funded projects' assumes achieving a 10% reduction in our energy emissions through implementing recommendations from our energy audits/decarbonisation plans, plus a further 330 tonnes CO_2e a year from exchanging gas boilers to heat pumps at West Berkshire Community Hospital. 'Funded projects + solar farm' assumes a further 116 tonnes a year saving from installing a proposed solar farm at West Berkshire Community Hospital.

We would achieve further reductions through the implementation of our upcoming Travel and Transport Strategy and removing fossil fuel heating from all our sites.
Our current greenhouse gas accounting spans the NHS Carbon Footprint and excludes our supply chain, which we know makes up most of our emissions. We are therefore exploring different ways to account for and reduce our procurement-related emissions under the NHS Carbon Footprint Plus, which will form part of our refreshed Green Plan in 2025.

Note that as per the Greenhouse Gas Protocol, we do not report emissions from

anaesthetic gases, fugitive emissions, and diesel for generators as these have been determined to account for <1% of our total emissions. The breakdown of hybrid vehicles (self-charging vs plug-in) is unknown, and therefore our calculations assume a current market split of 60:40, respectively.

Estates and Facilities

Strategy and Planning

Our estate is our Trust's largest source of direct carbon emissions – it's therefore the most significant opportunity to cut polluting emissions in line with current net zero legislation. Doing so brings greater resilience for the Trust, reduces our direct impact on public health, and safeguards future generations.

Sustainability has therefore been incorporated into the refreshed and upcoming Trust Estate Strategy. This aims to identify and implement opportunities to cut consumption, costs, and carbon so that the Trust can meet its net zero obligations and ensure the sustainability and resilience of its operations and services.

The sustainability aspect of the Strategy focuses on priority sites which do not reflect the entire Berkshire Healthcare estate but were selected based on either ownership or long-term occupation. Sites with short-term leases were excluded to avoid investment in properties that are at risk of being removed from the Trust's estate. It sets out goals and deliverables against major areas of work: Buildings, Travel, Waste, and Green Spaces, and will be published this year.

Energy and utilities

In line with NHS England requirements, we report on our utilities consumption figures through the Estates Return Information Collection (ERIC).

In 2024/25, Berkshire Healthcare spent £2.6 million on utilities, in comparison to £2.3 million in 2023/24, a 15% rise.

Our Trust's consumption of electricity increased compared to last year, whereas gas use shrunk. Electricity consumption was 6,246,460 kWh this financial year, compared to 6,018,819 kWh, a 4% rise. We used 10,512,663 kWh gas in 2024/25, compared to 11,335,084 kWh in 2023/24, a 7% drop. We also used slightly more water, 58,938 m3 compared to 57,471 m3. This may be attributed to a change in reporting, where NHSPS previously used an estimated benchmark for water consumption, which may have led to underreporting, whereas now actual reads are used which provide more accurate consumption data.

Our Estates team have installed water-saving Propel Air toilets at one of our sites, which use over 80% less water compared to traditional loos, or 4.5 fewer litres per flush. In just 2 months, installing 5 loos saved over 31,700 litres of water.

Since 2018/19 there has been a 2% increase in the Trust consumption of electricity, and a 9% decrease in gas, while the total Gross Internal Area included in our monitoring and reporting has increased by 31% over the same period. This means that there has been an overall downwards trajectory in terms of the intensity of utility consumption (how much we use per square metre of estate), which has fallen by 30% (electricity), 37% (gas), and 1.5% (water) since our baseline year.

Investment in renewables

We have fitted rooftop solar panels onto two sites – Erlegh House and Church Hill House. Since their installation, these have saved over 15 tonnes of CO_2e, equivalent to planting almost 1,000 trees. This is part of an ongoing programme, with three further sites identified for installation this year, which would save a further 8 tonnes annually, and a proposal is in development for a major solar farm at one of our hospitals, reducing emissions by over 100 tonnes a year.

Waste

We are committed to applying the waste hierarchy – reduce, reuse, repurpose, recycle – across all activities, minimising our reliance on disposable items and reducing overall waste generation. Improving waste segregation remains a key focus, alongside engaging staff in paper-light ways of working to drive more sustainable practices.

To support this, the Trust has conducted a comprehensive waste audit, which has informed the development of a new waste strategy. A key priority of this strategy is improving waste segregation, as certain disposal methods, such as high-temperature incineration, have a significantly higher carbon footprint. By reducing the volume of waste incorrectly directed into these high-impact streams, we can lower our environmental impact while ensuring compliance with best practice waste management.

Since data collection began in 2017, Trust general waste has reduced by approximately 10%. This means that the Trust has now met its previous Green Plan target of reducing general waste by 10% by 2023/24, one year late. Implementation of the Waste Strategy is therefore essential to ensure accelerated waste reduction, cutting costs and carbon. Compared to last year, total waste has risen by approximately 10%, largely owing to a rise in general and recycling waste. There has been a corresponding rise in spend.

Reducing waste saves both carbon and costs, and so a key area of focus this coming year will be to identify opportunities to shrink the amount we waste, for example by procuring reusables and educating staff to use less – for instance printing less and only buying what they need.

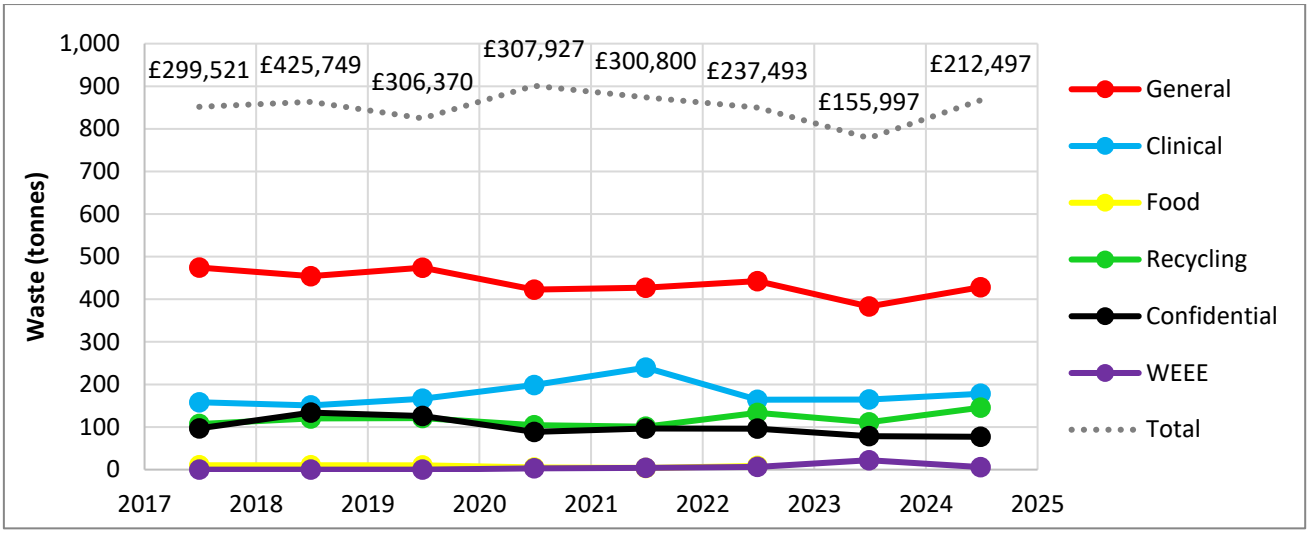


Figure 5: Trends in Berkshire Healthcare's waste and associated costs. This includes all Berkshire Healthcare sites (directly managed, plus PFIs and NHSPS-managed sites).

In 2024, our Trust entered a new waste contract with Veolia to cover all services – general, recycling, food, and clinical. Veolia divert 100% of our waste from landfill, reducing associated methane emissions, environmental contamination and unnecessary land use.

Procurement

As part of our ongoing efforts to embed sustainability into all aspects of our operations, the Trust has made strides in refining our procurement processes to align with carbon reduction and climate change goals. We have met the NHSE guidance that, from April 2024, the requirements of the Carbon Reduction Plan (CRP) will be extended to all procurements, ensuring that sustainability is a key consideration at every stage of the procurement process. The relevant Trust policy (Fighting Climate Change through Procurement) regarding tender assessments has been updated.

In line with NHS guidance, we have established sustainable procurement practices for all major contracts. Social value, including carbon reduction, is now a mandatory criterion for evaluation in all tenders, with carbon reduction being assessed at 10%. This ensures that our procurement decisions are aligned with both environmental and social responsibility. To meet NHS Net Zero Supplier Roadmap targets, we have adopted a graduated approach: full compliance for all contracts over £5m, detailed supplier inquiries for contracts exceeding regulated thresholds, and high-level information for contracts over £10k.

Furthermore, we have integrated climate change considerations into business continuity planning by developing a specific question for tenders. This is now part of the Social Value assessment for all contracts valued over £50k, ensuring that our suppliers are prepared for the long-term impact of climate change on their operations and can contribute to our broader sustainability objectives.

Travel and transport

As part of our commitment to reducing emissions from travel, we commissioned the Energy Saving Trust to conduct a comprehensive Travel and Transport Review. This review established a baseline for our transport-related greenhouse gas (GHG) emissions, examined business travel patterns, and assessed the potential for transitioning to more sustainable travel solutions.

The findings revealed that in 2022/23, our fleet and business travel accounted for 719 tonnes of carbon emissions, with business travel making up 94% of this total. Staff travel in private vehicles (grey fleet) remains the largest contributor, covering over 2 million business miles at a cost of approximately £1.26 million in mileage reimbursements. While overall mileage has decreased since pre-pandemic levels, there is significant potential to further reduce emissions and costs.

One of the key recommendations from the review was the transition of our Trust fleet to electric vehicles (EVs), which was achieved this year for Estates vehicles. The report outlines a plan to phase out all fossil fuel-powered vehicles by 2027 – eight years ahead of the NHS target of 2035. To support this, we will continue expanding EV charging infrastructure at key sites, ensuring that our fleet can operate efficiently on zero-emission technology.

The review also highlighted the need for a strategic approach to reducing emissions from business travel. This includes implementing a travel hierarchy to prioritise low-carbon travel options, introducing EV pool cars, and setting clear sustainability standards for grey fleet travel. By adopting these measures, we could achieve an annual reduction of up to 375 tonnes of CO2 and deliver potential cost savings of £418,000 per year.

These insights will directly inform our new Travel and Transport Strategy, due in 2026. This strategy will outline how we will continue to decarbonise travel across the organisation, reduce our reliance on private vehicles, and support staff in making more sustainable travel choices.

2024/25 travel data

Between 2023 and 2024, we made further progress in shifting our fleet towards low-carbon vehicles. However, overall mileage rose from 2.57 million to 2.75 million miles, with an associated increase in emissions.

Electrification Trends

The proportion of mileage from electric and hybrid vehicles increased from 10.0% in 2023/24 to 14.8% in 2024/25.

Internal combustion engine (ICE, petrol and diesel vehicles) mileage fell accordingly, from 90.0% to 85.2%.

The most substantial progress was seen in the company fleet, where electric and hybrid vehicles accounted for 42.6% of total mileage in 2024/25, up from 29.5% in 2023/24. In private vehicles, electric and hybrid share rose from 9.1% to 13.8%.

This continues a dramatic shift from our 2018/19 baseline, when just 0.6% of total mileage came from electric or hybrid vehicles.

Emissions

The positive impacts of the shift towards electrification are reflected in emissions savings.

Scope 1: Reduced from 109 tonnes CO_2e in 2018/19 to 28 tonnes in 2023/24, and 21 tonnes in 2024/25.

Scope 3: Dropped from 1,178 tonnes CO_2e in 2018/19 to 631 tonnes in 2023/24, with a rise to 867 tonnes in 2024/25 due to an increase in mileage, representing a 26% reduction from baseline, despite mileage reducing by only 12%.

Continued electrification and mode shift — alongside broader behaviour change — will be key to meeting our net zero goals in future years.

Biodiversity

We are committed to enhancing biodiversity across the Trust, recognising the vital role that access to nature and green spaces plays in supporting the psychological and physical wellbeing of staff, patients, and visitors. In April 2024, we completed the installation of a nature and wellbeing garden at Church Hill House, creating a calming and restorative space for staff. This garden, co-designed with staff and the Berkshire Buckinghamshire Oxfordshire Wildlife Trust, includes sensory areas with fragrant, pollinator-friendly plants and integrates features to protect and enhance existing wildlife habitats, including nesting and roosting sites.

The response from staff has been overwhelmingly positive, with feedback highlighting the garden as “a truly wonderful space” and “beautiful and well used by staff.” Staff set up a gardening group to keep it maintained, and teams even use the pergola – fitted with water butts to harvest rainwater for the plants, and trellises for creeping plants – to take meetings outside.

Building on this progress, further biodiversity improvements are underway at Abell Gardens and Whitley Clinics, where wildlife boxes will support local species such as swifts, sparrows, tits, robins, owls, and hedgehogs. Additionally, an Environmental Assessment at West Berkshire Community Hospital will incorporate a Biodiversity Survey, with plans to expand these surveys across more sites this year. These initiatives will contribute to the development of a Trust-wide biodiversity strategy, ensuring a structured and impactful approach to protecting and enhancing nature across our estate.

Our year ahead

Building on the progress made so far, the Trust will develop a new three-year Green Plan, ensuring it aligns with national and statutory guidance while being tailored to our role as a community and mental health provider. A key focus will be the implementation of our Sustainable Estates Strategy, using recommendations from decarbonisation plans and energy audits to drive cost-effective carbon reduction measures. Alongside this, we will roll out our new Waste Strategy, prioritising waste reduction, cost savings, and lower carbon emissions.

Staff engagement and education will remain central to our sustainability efforts, particularly in energy-saving initiatives. We will also finalise and implement a Sustainable Travel and Transport Strategy, expanding EV charging infrastructure where needed and progressing our commitment to net zero travel emissions. Further investment in renewable energy will be explored, with new solar panel installations and the progression of a proposed solar farm at West Berkshire Community Hospital.

Recognising the vital role of green spaces in health and wellbeing, we will also develop and implement a Biodiversity Strategy to enhance nature across our sites. Through these initiatives, the Trust will continue to embed sustainability into its operations, reducing environmental impact while delivering high-quality care.

Julian Emms

Chief Executive
18 June 2025

ACCOUNTABILITY REPORT

Directors' Report

The Trust Board comprises five Executive Directors and six Non-Executive Directors, plus the Chair and Chief Executive of the Trust. The Chair and the Non-Executive Directors are appointed for three-year terms of office by the Council of Governors. To ensure a strong shortlist of candidates for Non-Executive Director appointments, the Trust engages the support of External Recruitment Consultants. At the end of the first three-year term of office, the Council of Governors can re-appoint the Chair and the Non-Executive Directors for a further three-year term of office. The Council of Governors can also remove the Chair and Non-Executive Directors.

Up until December 2016, formal meetings of the Trust Board were held every month (except August). Following the Trust Board's evaluation of its effectiveness in October 2016, it was agreed that the Trust Board needed more time to discuss strategic issues and therefore from January 2017, the formal public Trust Board met seven times a year and held four private discursive meetings. The schedule of meetings was reviewed again as part of the Trust Board's Annual Review of Effectiveness in October 2023. The Trust Board agreed to increase the amount of time to discuss strategic issues by holding an additional Trust Board Discursive meeting (five discursive meetings) and reducing the number of public board meetings from seven to six per annum. An additional meeting is scheduled in August if required. An Extraordinary meeting of the Trust Board was convened in March 2025 to approve the Trust's Financial Plan 2025-26 submission.

At the formal public Trust Board meetings, no business can be conducted unless at least one third of Directors are present, including at least one Executive Director and one Non-Executive Director. From May 2020, our public Trust Board meetings have been held via MS Teams. A recording of the full meeting is published on the Trust's website along with the Trust Board agenda and papers. Members of the Public can request to attend and observe the meeting in real time. Members of the Public are also invited to submit questions to the Trust Board before the meetings. The questions are answered by the relevant Executive Director at the meeting and the full responses are included as part of the meeting minutes.

The Trust Board is responsible for:

- the exercise of the powers and the performance of the NHS Foundation Trust
- setting strategy, following discussion with the Council of Governors
- ensuring the provision of safe, high-quality services
- ensuring the highest level of corporate governance
- ensuring that the Trust operates an effective process for the management and mitigation of risk.

The Non-Executive Directors are 'held to account' for the performance of the Trust Board by the Council of Governors. The Trust Board meets formally with the Council twice a year and Governors normally meet Non-Executive Directors on a further two occasions each year. Executive Directors routinely attend Council of Governor meetings, and the Chief Executive presents to Council a quarterly performance report covering key aspects of the Trust's performance, both financial and service related.

The Council of Governors was mindful that the NHS was moving into a period of significant legislative change when the Integrated Care Systems were put on a legal footing. As the Trust was split between two different Integrated Care Systems, the need for a strong chair and stable board was even more important during the next couple of years. The Council of Governors therefore agreed in September 2021 to extend the term of office of the Trust Chair for a further three years upon the expiry of his current term of office, subject to the outcome of satisfactory annual appraisals.

Martin Earwicker, Trust Chair was also appointed as the Chair of Hampshire Hospitals NHS Foundation Trust with effect from 1 January 2025. Martin Earwicker agreed to undertake both roles until his successor was appointed. Recruitment for a new Chair will start in April 2025 with an appointment expected to be made in July 2025.

Recruitment is also underway for a Non-Executive Director to replace Naomi Coxwell who will be leaving the Trust once her successor has been appointed. It is expected that her successor will be appointed in May 2025.

Dr Minoo Irani, Medical Director retired from the Trust at the end of March 2025. Tehmeena Ajmal, Chief Operating Officer, also left the Trust at the end of March 2025 to take up another role.

Given the recent and upcoming Board changes and Council of Governors agreed to extend the term of office of Mark Day, Vice Chair, for a further six months upon the expiry of his current term of office. The Council was mindful that Mr Day will have served 9.5 years when his extended term ends, but the Council of Governors felt that a newly appointed Trust Chair would benefit from having an experienced Vice Chair to support their induction into Berkshire Healthcare.

The Council also agreed to re-appoint Sally Glen, Non-Executive Director, for a second term of office and to extend the term of office of Aileen Feeney, Non-Executive Director, for a further one year upon the expiry of her current term of office.

Directors in post during 2024-25 are shown in the following table:

Name	Position	From	To
Martin Earwicker	Chair (Non-Executive Director)	01.12.16	31.07.25
Rebecca Burford	Non-Executive Director	01.07.23	30.06.26

Name	Position	From	To
Naomi Coxwell	Non-Executive Director	13.12.17	31.05.25
Mark Day	Non-Executive Director	01.09.16	28.02.26
Aileen Feeney	Non-Executive Director	01.11.19	31.10.26
Rajiv Gatha	Non-Executive Director	01.10.21	30.10.27
Sally Glen	Non-Executive Director	01.06.22	31.05.28
Julian Emms	Chief Executive	01.07.12	N/A
Debbie Fulton	Director of Nursing and Therapies	01.12.18	N/A
Paul Gray	Chief Financial Officer	01.11.21	N/A
Alex Gild	Deputy Chief Executive and Chief Financial Officer Deputy Chief Executive	01.04.11 07.06.21	06.06.21 N/A
Minoo Irani	Medical Director	19.07.16	28.03.25
Tehmeena Ajmal	Chief Operating Officer	14.05.22	31.03.25

Independent External Well-Led Review

The Trust Board commissioned an independent consultancy firm, DCO Partners, to conduct an external Well-Led Governance Review. DCO Partners has no other connection with the Trust or to individual directors. The review commenced in January 2023 and consisted of one-to-one interviews with members of the Trust Board, Board and Sub-Committee observations, a focus group with the governors and a desk top review of documentation.

The External Review concluded that Berkshire Healthcare was a very high-performing Trust and was rightly proud of its reputation and made the following observations:

"The Board is providing leadership in an environment of turbulence and change, and in an emerging system that is complex and not fully formed, with plenty of fragmentation in terms of geography and organisation."

The External Reviews recommendations were:

I. Strategy development needs more specificity, to allow the Non-Executive Directors to engage and to translate the aspirations of the Trust into concrete plans over a 5-year timeframe and led by the Trust Board. From this can follow harder-edged strategic objectives

II. A board development plan is now needed to cover a variety of new areas and to reflect gaps in knowledge on the part of Non-Executive Directors. Areas to cover include:
    - Developing a risk appetite
    - A better understanding of system working and the impact of working with two very different Integrated Care Systems, now that they are up

and running.

- Understanding the potential for collaboration with stakeholders such as Local Authorities, the Voluntary Sector and Private healthcare, and how best to negotiate this.
- A dedicated programme to pursue innovation and ideas generation.

III. The Trust is capable of more innovation, especially in the digital area, and the Board should discuss faster progress as part of its strategy and consider taking on a digital partner.

IV. The Board should consider how best to support the Governors over their Public duty and to look for opportunities to work with Non-Executive Directors

V. The Trust should consider establishing a shadow board to expose suitable candidates to the work of senior leadership and promote diversity.

The Trust drew up an action plan to take forward the recommendations which was presented to the July 2023 and December 2023 public Trust Board meetings. The Trust Board signed off the completed action plan at its meeting in July 2024.

Trust Board and Sub-Committee Annual Review of Effectiveness

The Trust Board and Board Sub-Committees conduct annual reviews of effectiveness via a self- assessment survey.

The Trust Board undertook its annual review of effectiveness in the summer of 2024. Overall, the results were very positive. The quality of Board reports and in particular, Board cover sheets were identified as an area for improvement. The Board agreed to include a standing agenda item at the end of the private meeting on whether there were any reports which could have been better written. The Board's comments would then be relayed to the report author.

The results of the surveys are reported to the respective Board and Sub- Committees. In addition, the Audit Committee receives the self-assessments of the other Sub-Committees as part of its corporate governance assurance work.

Members of the Trust Board – Annual Appraisals

The Chief Executive is responsible for conducting the annual appraisals for each of the Executive Directors. The Chair undertakes the Chief Executive's annual appraisal. The Senior Independent Director undertakes the Chair's annual appraisal which is overseen by the Council of Governors' Appointments and Remuneration Committee. The Trust Chair undertakes the annual appraisals of the Non-Executive Directors and provides a summary of the outcome of each appraisal to the Council of Governors' Appointments and Remuneration Committee.

Register of Interests

The Trust maintains a Register of Interests for all members of the Trust Board providing details of any Company Directorships and any other relevant significant business interests held that may conflict with any management responsibilities. This Register is published on the Trust's website at: https://www.berkshirehealthcare.nhs.uk/about-us/key-documents/reports-policies-and-procedures/ or may be obtained upon request to the Trust's Company Secretary.

Focus on Quality

The Trust's latest comprehensive inspection by the Care Quality Commission took place in November and December 2019. The Trust received an overall rating of "Outstanding."

The Care Quality Commission's ratings in respect of the five quality domains in set out below:

CQC Domains	Rating	
Are Services Safe?	Good	
Are Services Effective?	Good	
Are Services Caring?	Good	
Are Services Responsive?	Outstanding	
Are Services Well-Led?	Outstanding	
Overall Rating	**Outstanding**	

In April 2017, the Trust launched its Quality Improvement Programme with the aim of enabling the organisation to apply a consistent approach to continuous improvement by developing the ability of every staff member to become problem solvers and make improvements to the way we deliver care for our patients. Quality of service and patient experience remain top priorities for the Trust Board with quality being set at the top of the Trust Board's agenda each month. Non-Executive Directors and Governors make visits to services. The Trust also has a programme of 15 Step Visits.

A key aspect of Quality Improvement is to increase the Executive Directors' value-added activity, with value being defined by the customer. The ultimate customer in healthcare is the patient/service user, but for some services this could be another team or partner organisation. W e have introduced to support our goal of increasing Executive Director value is through Gemba visits/walks. Gemba is a Japanese word defined as "the actual place" and in Quality Improvement terminology this is "where value is added." Gemba is

the place where real value is created or delivered for the customer – so this is normally where care givers are directly helping patients/service users, as that is what they value.

The purpose of a Gemba visit is to take time to observe and interact with people at the Gemba, to learn and understand what is really happening. There are a number of benefits from this:

- People going to Gemba can see and understand how things are really done to help them with their own "value adding" work.
- Leaders can support front line staff by seeing and hearing about the improvement work and identify things which can be escalated and supported.
- People can see how our Quality Management Improvement System is operating at the Gemba to help with their Quality Improvement training, learning and the development of Quality Improvement in our Trust.
- It provides an opportunity to practice Quality Improvement skills and Quality Improvement leadership behaviours.

The Trust Board agenda includes a patient story at the start of the meeting.

The Quality and Performance Executive Group, chaired by the Chief Executive, meets monthly to review quality related issues, such as patient safety and learning incidents, quality concerns and the minutes of the locality and service monthly Patient, Safety and Quality meetings. The meeting also reviews performance and waiting times. The Quality Assurance Committee (Trust Board Sub-Committee), which meets quarterly, continues to provide an opportunity for Non-Executive and Executive Directors to debate and scrutinise the Trust's quality strategy, processes and performance in greater depth and to provide a forward-looking perspective on the quality agenda.

Further information about the Trust's quality performance can be found in the Quality Accounts Report 2024-25 available from the Trust's website.

Code of Governance for NHS Provider Trusts Compliance

Berkshire Healthcare NHS Foundation Trust has applied the principles of the Code of Governance for NHS Provider Trusts on a 'comply or explain basis. The Code of Governance was most recently revised in October 2022 and is based on the principles of the UK Corporate Governance Code issued in 2012.

As a Trust we are committed to high standards of corporate governance. For the year ended 31 March 2023, the Board considers that it was, throughout the year, fully compliant with the provisions of the Code of Governance for NHS Provider Trusts.

Code Reference	Annual Report Section	Page No
A.2.1	Consideration of opportunities and risks to future sustainability	P7
A.2.3	Staff Report – NHS Staff Survey Results	P103
A.2.8	Stakeholder Relations	P82
B. 2.6	Trust Board Members - Independence of Non-Executive Directors	P78
B.2.13	Attendance at Board and Sub-Committee Meetings	P71
B.2.17	Council of Governors and Trust board Dispute Resolution Process	P117 and P120
C.2.5	External Consultancy – Appointment of Non-Executive Director and External Well Led Review	P59 and P61
C.2.8	Appointment of Non-Executive Directors	P60
C.4.2	Directors' Biographies	P73
C.4.7	External Well-Led Review	P61
C.4.13	Appointments and Remuneration Committee Equality, Diversity and Inclusion Section Staff Report - Talent Management	P70, P25 and P98
C.5.15	Membership	P122
D.2.4	Annual Governance Statement	See Annual Account
D.2.6	Statement of Accounting Officer's Responsibilities	See Annual Accounts
D.2.7	Annual Governance Statement	See Annual Accounts
D.2.8	Annual Governance Statement	See Annual Accounts
D.2.9	Going Concern Statement	P11
E.2.3	Not applicable	
Appendix B, para 2.3 (not in Schedule A)	Membership of the Council of Governors	P117
Appendix B, para 2.14 (not in Schedule A)	Contacting our Governors and Directors	P126
Appendix B, para 2.15 (not in Schedule A)	Working Relations between the Council and Trust Board	P119
Additional requirement of FT ARM resulting from legislation	Power to require one or more of the directors to attend a governors' meeting for the purpose of obtaining information about the foundation trust's performance of its functions or the directors' performance of their duties	N/A

NHS System Oversight Framework

NHS England's NHS Oversight Framework provides the framework for overseeing systems including providers and identifying potential support needs. NHS organisations are allocated to one of four 'segments.

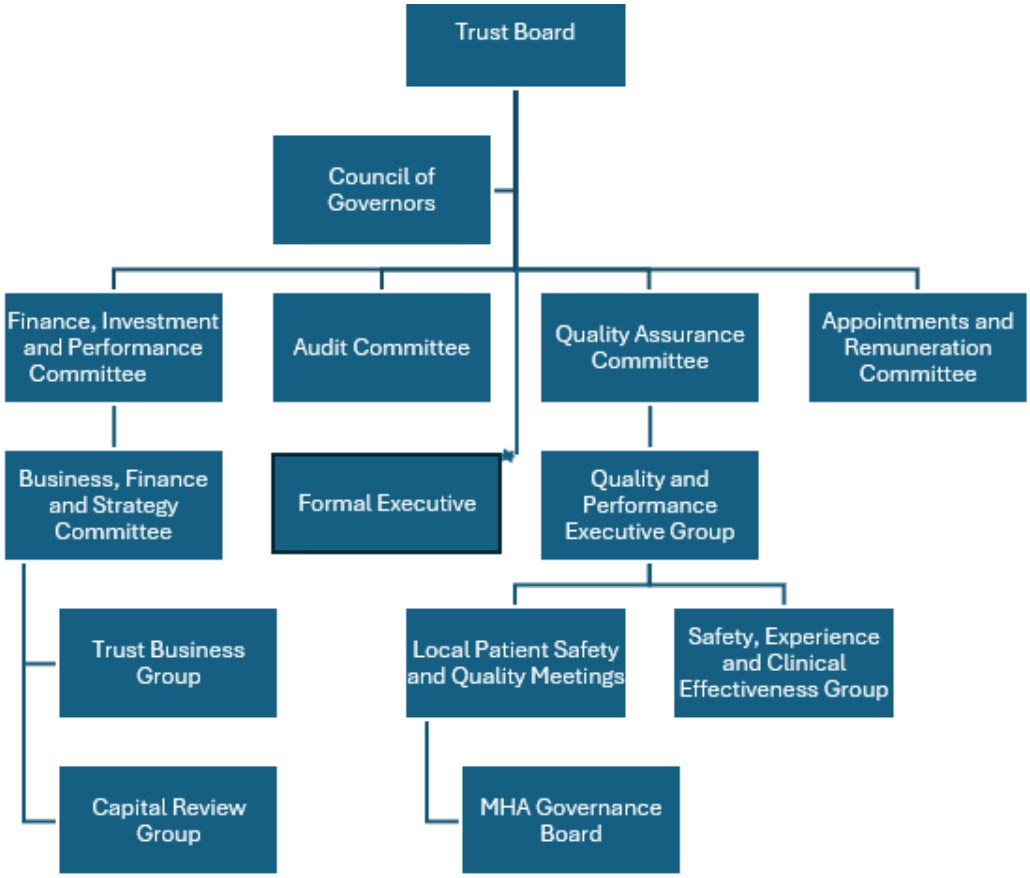
A segmentation decision indicates the scale and general nature of support needs, from no specific support needs (segment 1) to a requirement for mandated intensive support (segment 4). A segment does not determine specific support requirements. By default, all NHS organisations are allocated to segment 2 unless the criteria for moving into another segment are met. These criteria have two components:

- objective and measurable eligibility criteria based on performance against the six oversight themes using the relevant oversight metrics (the themes are: quality of care, access and outcomes; people; preventing ill-health and reducing inequalities; leadership and capability; finance and use of resources; local strategic priorities)
- additional considerations focused on the assessment of system leadership and behaviours, and improvement capability and capacity.

Throughout the year, the Trust has operated in compliance with our NHS Provider Licence and continue to be in segment 1.

Governance Framework

The Trust operates a comprehensive structure and reporting arrangements which facilitate robust governance throughout the organisation involving the Council of Governors, the Trust Board and various committees. The diagram overleaf provides a view of the high-level governance and reporting arrangements that were in place during 2024-5 to provide appropriate governance and assurance.



The Trust Board, led by the Trust Chair, sets the strategic direction of the Trust and is responsible for the organisation's decision-making and performance to ensure the delivery of high quality, safe and efficient services.

The effectiveness of the Trust's governance arrangements is regularly assessed, including through internal and external audits. The Trust Board places great emphasis on the achievement of high-quality services and uses several different sources of information to monitor and triangulate performance and to provide robust assurance. The Trust Board receives a detailed True North Performance Scorecard report at each meeting which presents information across the whole spectrum of the Trust's activity with reference to quality measures. This report is scrutinised further on behalf of the Trust Board by the Finance, Investment and Performance Committee.

Streams of assurance on quality include internal and external audit activity, patient and staff satisfaction surveys, quarterly patient experience reports to the Trust Board and virtual and physical or virtual visits to clinical services conducted by members of the Trust Board.

Reports are also received on subjects such as compliments and complaints, learning from deaths, patient safety and learning incidents (including details of any lessons learned), infection prevention and control and compliance with Care Quality

Commission regulations. These and other information sources are used to assure the Trust Board of its duty to provide regular quality declarations to NHS England.

Clinical Directors are responsible for maintaining a focus on local quality issues and for ensuring that best practice is identified and shared across the organisation. This is supported by the corporate governance arrangements in place and by the patient safety function which undertakes activity to monitor the Trust's compliance with the Care Quality Commission's regulations.

The Trust operates fully in compliance with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 5: Fit & Proper Persons and all Directors are required to meet these requirements and to declare such annually. In addition, in the case of all new Directors, appropriate checks are made in accordance with the fit and proper person regulations before an appointment can be confirmed. In addition, members of the Trust Board are required to abide by the Board's Code of Conduct which reflects the high standards of probity and responsibility which are required of all Board members.

In line with constitutional requirements, the Trust maintains a register of interests for Directors which is available on the Trust's website or from the Company Secretary. The Company Secretary attends the Trust Board and its Sub-Committee meetings and produces detailed minutes of the discussions. Any concerns about a proposed course of action will be recorded in the minutes in line with the Code of Governance for NHS Provider Trusts' requirements.

Trust Board Committees

During 2024-25 the Trust Board had five standing committees that helped it discharge its duties.

Audit Committee

The Audit Committee, comprising only Non–Executive Directors, is responsible for making sure the Trust governs itself well by concluding on the adequacy of the Trust's systems of internal control and its assurance framework. The main roles and responsibilities are set out in the terms of reference approved by the full Trust Board, which are consistent with national guidance.

These responsibilities include:

- monitoring the integrity of the financial statements of the Trust and any formal announcements relating to the Trust's financial performance and reviewing significant financial reporting judgements contained in them
- reviewing the Trust's internal financial controls and the internal control and risk-

management systems
- monitoring and reviewing the effectiveness of the Trust's internal audit function
- reviewing and monitoring the external auditor's independence and objectivity, and the effectiveness of the audit process, taking into consideration relevant requirements
- monitoring progress and output from the Trust's clinical audit activity; and
- Reviewing the annual clinical audit plan.

The Audit Committee has met these responsibilities by:

- Overseeing internal audit, counter fraud, and external audit services by:
    - reviewing the audit and counter fraud strategies and annual plans
    - receiving progress reports
    - considering the major audit findings and management's responses
    - holding discussions with internal and external audit
    - ensuring co-ordination between external and internal auditors
    - reviewing the external audit management letter; and
    - reviewing clinical audit summary reports
- Reviewing and monitoring compliance with the Trust's Standing Orders and standing financial instructions
- Monitoring and advising the Trust Board on the Trust's Board Assurance Framework and Corporate Risk Register
- Reviewing schedules of losses and special payments
- Reviewing the annual accounts of the Trust before submission to the Trust Board and Charitable Funds Trustees, focusing particularly on:
    - changes in and compliance with accounting policies and practices
    - major judgmental areas
    - significant adjustments resulting from the audit
- Receiving and reviewing minutes from the Finance, Investment and Performance Committee and the Quality Assurance Committee
- Ensuring that both internal and external auditors have full, unrestricted access to all the Trust's records, personnel, and the Audit Committee members.

The Audit Committee reviewed financial and operating performance and compliance against national and regulatory standards. The Committee's review was supported by reporting from the Chair of the Finance, Investment and Performance Committee. In-depth reviews of strategic and operational risks have further supported the Committee's understanding and review of the key issues facing the Trust.

The continuing effectiveness of both the internal and external auditors is monitored by the Committee, as is the Committee's own effectiveness through self-assessment against best practice standards.

The Audit Committee also considers the key risks identified by the External Auditor and uses its resources and the internal audit programme to provide assurance around the following key areas: management override, property valuations and completeness of accruals.

Auditor's Independence

The Trust requires its Auditors to demonstrate the policies and procedures they use to ensure they remain independent while carrying out their duty. During the year, the only work appointed by the Trust has been the audit, and the independent examination of the charity (which is non-audit but clearly audit related assurance services).

Finance, Investment and Performance Committee

The Finance, Investment and Performance Committee, comprising both Non-Executive and Executive Directors is responsible for reviewing financial and operational performance and for reviewing and providing expert comment on all significant financial investment and disinvestment decisions. They also scrutinise reporting on safe staffing and business development activity. On behalf of the Trust Board, the Committee oversees the implementation of the People Strategy's recruitment and retention work.

The Committee receives the minutes of the Trust Business Group and the Business, Finance and Strategy Executive Committee.

Quality Assurance Committee

This Committee provides a forum for detailed scrutiny and consideration of the Trust's quality agenda and provides assurance to the Trust Board about the quality of clinical services This includes, but is not restricted to: review of infection control performance, organisational learning from incidents including learning from deaths, review of the Guardians of Safe Working Hours of Doctors and Dentists in Training, performance against quality priorities, Care Quality Commission inspection reports, progress in implementing action plans to address shortcomings in the quality of services, Trust safeguarding assurance and quality concerns. Membership of the Committee includes both Non-Executive and Executive Directors. The Trust's Patient Safety Specialist and Patient Safety Partner (a member of the public) also attend the meetings.

Appointments and Remuneration Committee

The Appointments and Remuneration Committee is comprised of all Non-Executive Directors and is chaired by Mark Day, Non-Executive Director. The Committee is responsible for ensuring that there is a robust process in place for appointing Executive

Directors and Very Senior Managers and for determining Executive Director and Very Senior Managers remuneration. The Committee is also responsible for ensuring that the Trust has an effective Talent Management and Succession Planning process in place.

The Chief Executive attends meetings but is not present for discussions relating to his own remuneration or terms and conditions. The Committee is supported by the Director of People and the Company Secretary.

More information about Non-Executive and Executive Director remuneration can be found in the Remuneration Report later in this report.

The Appointments and Remuneration Committee should not be confused with the Council of Governors Appointments and Remuneration Committee, which considers the appointment and conditions of Non-Executive Directors.

Attendance at Board meetings and Committees 2024-25

Board Meetings

Name	Position	Meetings attended/possible*
Martin Earwicker	Chair	11/12
Rebecca Burford	Non-Executive Director	11/12
Sally Glen	Non-Executive Director	12/12
Naomi Coxwell	Non-Executive Director, *Senior Independent Director (until 11 03 25)*	12/12
Mark Day	Non-Executive Director, Vice-Chair	10/12
Aileen Feeney	Non-Executive Director *(Senior Independent Director* (*from 12 03 25*)	10/12
Rajiv Gatha	Non-Executive Director	09/12
Julian Emms	Chief Executive	10/12
Debbie Fulton	Director of Nursing and Therapies	11/12
Alex Gild	Deputy Chief Executive	11/12
Paul Gray	Chief Financial Officer	11/12
Minoo Irani	Medical Director	11/12
Tehmeena Ajmal	Chief Operating Officer	12/12

**Includes attendance at both the Public Trust Board meetings and private discursive meetings.*

Audit Committee Meetings

Name	Position	Meetings attended/possible
Rajiv Gatha (Chair)	Non-Executive Director	05/05
Naomi Coxwell	Non-Executive Director	04/05
Mark Day	Non-Executive Director	04/05
Aileen Feeney	Non-Executive Director (substituting for Naomi Coxwell, Non-Executive Director	01/01

Finance, Investment and Performance Committee Meetings

Name	Position	Meetings attended/possible
Naomi Coxwell (Chair)	Non-Executive Director	05/05
Mark Day	Non-Executive Director	05/05
Aileen Feeney	Non-Executive Director	05/05
Sally Glen	Non-Executive Director	05/05
Julian Emms	Chief Executive	05/05
Paul Gray	Chief Financial Officer	05/05
Tehmeena Ajmal	Chief Operating Officer	05/05
Debbie Fulton	Director of Nursing and Therapies	05/05

Appointments and Remuneration Committee Meetings

Name	Position	Meetings attended/possible
Mark Day (Chair)	Non-Executive Director	02/02
Martin Earwicker	Trust Chair	01/02
Rebecca Burford	Non-Executive Director	01/02
Sally Glen	Non-Executive Director	02/02
Naomi Coxwell	Non-Executive Director	02/02
Aileen Feeney	Non-Executive Director	01/02
Rajiv Gatha	Non-Executive Director	02/02
Julian Emms	Chief Executive	01/02

Quality Assurance Committee

Name	Position	Meetings attended/possible
Sally Glen (Chair)	Non-Executive Director	04/04
Rebecca Burford	Non-Executive Director	03/04
Aileen Feeney	Non-Executive Director	01/04

Name	Position	Meetings attended/possible
Julian Emms	Chief Executive	02/04
Minoo Irani	Medical Director	03/04
Debbie Fulton	Director of Nursing and Therapies	04/04
Tehmeena Ajmal	Chief Operating Officer	03/04
Alex Gild	Deputy Chief Executive	04/04
Mark Day	Non-Executive Director (deputising for Aileen Feeney, Non-Executive Director	01/01

All Board Committees are supported by the Company Secretary and such other senior personnel as required.

Trust Board Members

Martin Earwicker – Chair

Martin Earwicker became Chair of Berkshire Healthcare NHS Foundation Trust in December 2016, prior to this he was Vice Chair of Dorset County Hospital NHS Foundation Trust. From 1 January 2025, Martin was also the Chair of Hampshire Hospitals NHS Foundation Trust.

He retired from being Vice Chancellor of London South Bank University in 2013. Before this he was Director and Chief Executive of the Science Museum Group. However, his main career was in scientific research working for the Ministry of Defence interspersed with senior appointments in Whitehall; for the last five years of which he was Chief Executive of the Ministry of Defence's Research Laboratories, the Defence Science and Technology Laboratory.

In addition to his interest in health, he is a keen supporter of Further Education colleges and was chair for more than six years of Tower Hamlets College in the east end of London serving a particularly disadvantaged community, and for some 14 years as chair of Farnborough College of Technology. He has also been a Trustee of his local Citizens Advice Bureau.

He read Physics at Surrey University, graduating in 1970. He was appointed a Fellow of the Royal Academy of Engineering in 2000 and has been a vice president of the Academy and was awarded an Honorary Doctorate of Surrey University in 2009. He is an Emeritus Professor of London South Bank University.

Rebecca Burford – Non-Executive Director

Rebecca joined Berkshire Healthcare as a non-executive director in July 2023.

She is a qualified solicitor and a Partner with an international law firm, specialising in corporate mergers and acquisitions, private equity and venture capital investments, predominantly working with the technology business. She also sits as an appointed member of the Law Society's Ethnic Minority Solicitors' committee.

Both her parents have previously worked for the NHS, so the organisation is close to her heart, and she enjoys being able to contribute to the strategy and direction of the Trust, bringing her experiences from the corporate sector and her diversity of thought.

Naomi Coxwell – Non-Executive Director, Chair of the Finance, Investment and Performance Committee and Senior Independent Director until *March 2025*

Naomi Coxwell joined Berkshire Healthcare as a Non-Executive Director on 13 December 2017. She lives in Farnham, Surrey and is also a Non-Executive Director for Arco - a safety specialist company and also for James Walker Group Ltd - a global manufacturing and engineering firm. More recently she was appointed as Director of BP Pension Trustees Limited.

Naomi is a former Vice President of BP and worked in the oil and gas industry for over 30 years. She is a graduate of Exeter University where she received a bachelor's degree in Geology in 1984, and studied at The Warton School, University of Pennsylvania, where she received BP's Chief Financial Officer Excellence certificate in 2012. In August 2021 Naomi completed a course in Business Sustainability Management run by the University of Cambridge.

Naomi started her career in 1984 with Petrofina and was one of the first women to work as a Geologist on offshore rigs in the United Kingdom. She joined BP in 2000 and spent the following 16 years working overseas in increasingly senior positions. She has led diverse, multicultural teams in the development of strategy, management of risk, and in driving continuous improvement across six continents.

Naomi believes that the physical and psychological health of individuals is the single biggest contributor to societal strength and productivity and sees Berkshire Healthcare as being a major contributor to that cause.

Mark Day – Non-Executive Director, Chair of the Appointments and Remuneration Committee and Vice Chair

Mark Day joined Berkshire Healthcare as a Non-Executive Director on 1 September 2016. Mark until recently was the Chairman of Haven West Berkshire Homeless Charity. Haven operates a Soup Kitchen in Newbury for the homeless and vulnerable in West

Berkshire.

Mark started his career with Crookes Healthcare (subsequently Boots Pharmaceuticals) and then moved to the Automobile Association where he embarked on his Human Resources career path. A number of different Human Resources-related roles were undertaken until the organisation was acquired by the Centrica Group. Feeling that the time was right for a move into a different industry sector, Mark joined the Board of the Hospital Saving Association as Director of Human Resources.

Shortly after joining the Hospital Saving Association (subsequently becoming Simplyhealth) Mark assumed Director responsibility for the customer service operation and focussed on improving the personal service provided by the organisation. In addition to achieving consistent years of being in the Sunday Times 100 Best Companies to Work For, many industry awards were achieved for the exceptional service provided to both corporate clients and individual customers.

Mark firmly believes that people can be the only true differentiator in organisations and is keen to see Berkshire Healthcare continue to provide support across our communities based on this principle.

Aileen Feeney, Non-Executive Director (Senior Independent Director from March 2025)

Aileen Feeney joined Berkshire Healthcare NHS Foundation Trust as a Non-Executive Director in November 2019. Her career spanned both the commercial and charity sectors, most recently as Chief Executive for a UK-wide patient support charity.

Aileen spent most of her career in the Energy industry, in senior leadership roles that focussed on strategic business and technology transformation both in the UK and overseas.

Aileen holds several voluntary positions including being Lay Member for NHS Blood & Transplant, Trustee of a mental health support charity and a Member of Wokingham School's Circle Trust

Aileen has lived with her family in Berkshire for over 30 years. She has an Honours Degree in Biomedical Electronics, is a Chartered Engineer and an Associate of the London College of Music.

Rajiv Gatha, Non-Executive Director and Chair of the Audit Committee

Rajiv Gatha joined Berkshire Healthcare as a Non-Executive Director on 1 October 2021. He lives in Finchampstead with his wife and two sons, having spent most of his life in the local area.

He is a graduate of the London School of Economics where he received a bachelor's

degree in 1992, following which he qualified as a Chartered Accountant within the audit practice at Deloitte.

After his six years at Deloitte, Rajiv spent the rest of his career working for multinational IT companies in various Finance roles. He has been working at Cisco since 2008, where amongst other roles, he has been on the Cisco UK Pension Plan Governance Committee and a Trustee of their UK Healthcare Trust. Currently he is Vice President of Finance, supporting the Cisco Customer Experience organisation and manages a large team across the Americas, Europe, Middle East, Africa, and Asia.

Sally Glen, Non-Executive Director and Chair of the Quality Assurance Committee

Sally Glen became a Non-Executive Director of Berkshire Healthcare Foundation Trust in June 2022. Prior to this she was a Non-Executive Director of West London NHS Trust, Leeds Partnership NHS Trust, and East London NHS Foundation Trust. She retired from being Deputy Vice Chancellor at Leeds Beckett University in 2014. She was also Dean of Health at the University of Dundee and City University of London.

Sally has a particular interest in mental health. She is a Trustee of Certitude London and Chairs the Quality Committee. She is a Trustee of the Cassel Hospital. She Chairs Metanoia Institute and she is also a Governor of a Primary School.

Sally trained and worked as Children's Nurse and an Adult Nurse. She sits on the Nursing and Midwifery Council's Professional Standards. She has a PhD from the University of Southampton. She continues to supervise mid-career health professionals undertaking PhDs.

Julian Emms OBE – Chief Executive

Julian was appointed Chief Executive in July 2012, following a nine-month period during which he was the acting Chief Executive. Julian started his career in the Probation Service as a Support Worker and went on to undertake a variety of roles in the service over a 10-year period before joining the NHS in 1997.

An NHS Executive Director since 2004 Julian has wide ranging experience in organisational leadership and service improvement. Julian was part of the Trust's successful NHS foundation trust application in 2007 and was the project director who oversaw the integration of community health services into the Trust in 2011.

Julian's senior management roles prior to becoming a director were all joint posts with social care and focused on providing better integrated care for local people.

Julian is currently leading a Temporary Staffing Provider collaborative across the Southeast Region.

Julian is also the chair of the NHS Benchmarking mental Health Reference Group, a

position he has held since January 2016.

Julian was awarded an OBE for services to the NHS in the 2025 New Year Honours List.

Debbie Fulton - Director Nursing and Therapies

Debbie qualified as a nurse in 1989. She has enjoyed a varied career, having held a variety of nursing as well as clinical and operational management positions across Berkshire since 1998 and prior to that as a nurse and ward manager at Frimley Park Hospital.

Debbie has worked within Berkshire Healthcare since the merger with East and West Community organisations in 2011 and undertook clinical and locality Director roles as well as the roles of Deputy Director Nursing prior to taking up her current position in December 2018.

Alex Gild – Deputy Chief Executive

Alex joined the Trust in September 2006. A business graduate and a qualified accountant, he started his NHS finance career as a trainee finance assistant in 1996 with spells working in the acute trusts in Oxford, before latterly joining South Central Strategic Health Authority.

Alex was Deputy Director of Finance at Berkshire Healthcare NHS Foundation Trust and was appointed Executive Director of Finance in April 2011 (his title changed to Chief Financial Officer in March 2017) and was appointed Deputy Chief Executive in April 2019.

In June 2021, Alex's portfolio changed, and he ceased being the Chief Financial Officer. Alex stepped into a broader Deputy Chief Executive portfolio, responsible for strategy, partnerships, human resources, diversity and inclusion, transformation, quality improvement, IM&T and communications.

Alex is a provider partner member of the Frimley Integrated Care System's' Integrated Care Board (ICB), representing community services. Alex chairs the ICB finance and performance subcommittee and is co-chair of the Frimley ICB Mirror Board.

Alex Is a past president of the Healthcare Financial Management Association (2018) and since 2021 reappointed member of the National Advisory Board for NHS Supply Chain and chair of the south advisory forum.

Dr Minoo Irani – Medical Director

Minoo has been working in Berkshire as Consultant Community Paediatrician since 2001 and has held positions as Lead Paediatrician, Clinical Director, Lead Clinical Director and

Acting Medical Director in the Trust before being appointed as Medical Director in July 2016. Minoo has a master's in health management from Imperial College, London and professional qualifications from the United Kingdom, India and the United States.

Minoo retired from the Trust in March 2025.

Paul Gray – Chief Financial Officer

Paul joined the Trust in 2018 as Director of Finance and was appointed as Chief Financial Officer in November 2021. Paul started his NHS career in 1999 on the National Graduate Financial Management Training scheme. He was previously Associate Director of Finance at Hampshire Hospitals, and prior to that held a number of senior roles at both acute and specialist providers.

Tehmeena Ajmal – Chief Operating Officer (until March 2025)

Tehmeena started working for the NHS in 1994, having previously worked in the charitable and local authority sectors. Her roles have included service improvement, programme delivery, governance and risk, and operational management and leadership. She has worked across acute, ambulance, commissioning and community and mental health services.

More recently she led the covid vaccination programme across the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System area and was appointed to the role of Chief Operating Officer in Berkshire Health in 2022. Tehmeena is also a Deputy Lieutenant in Oxfordshire and a trustee of Age UK Oxfordshire.

Tehmeena left the Trust 0n 31 March 2025 to take up the role of Chief Operating Officer at Betsi Cadwaladr University Health Board.

Independence of Non-Executive Directors

None of the Directors have any declared political activities and all are considered independent.

Directors' Expenses

Directors are entitled to claim expenses in accordance with their terms and conditions of appointment. Expenses primarily relate to travel and car parking charges and for 2024-25, 7 Directors (out of 13) claimed expenses with an aggregate value of £7,529.78.

Patient Experience 2024/25

"I Want Great Care" (iWGC) Patient Experience Tool

The "I Want Great Care" (iWGC) patient experience tool is our primary patient survey programme. The tool was introduced in December 2021 and is available to patients to complete via online SMS, paper, and electronic tablet; it is offered to patients following a clinical outpatient contact or, for inpatient wards, on discharge.

This tool is used to measure patient experience in a standardised way across all teams and services within the organisation, and this data is available to teams and services in real time, supporting understanding of patient experience and improvement activity. The experience data can be viewed not only at organisational and service level, but also by differing demographics meaning that we can see if there is inequality of experience by protected characteristics. This information has been used over the year to inform and support the Trust's commitment to the Patient and Carer Race Equality Framework (PCREF).

All services have access to a tableau dashboard detailing response to our patient survey including free text comments and this is refreshed daily to enable live data to be used by services alongside improvement work being undertaken. We have introduced further filters into the dashboard, which means that services can drill down into the feedback given by people by characteristic, including those who are Neurodiverse.

The tool uses a 5-star scoring system as an overview as well as free text to capture the patients overall experience alongside their experience around facilities, staff, information, feeling listened to, ease of access, involvement, and safety. Free text invites our patients to comment on both their experience and suggested improvements. The tool includes the friends and Family test questions to enable us to continue to capture and report this.

We are seeing an increase in the number of responses received, which supports areas for improvement alongside hearing the patient voice both where the experience is good and where improvements can be made.

There were 39,771 responses on iWGC during 2024/25, an increase of 36% from the previous year (29,229) and a sustained increase from 16,405 during 2022/23.

The average positive experience score continues to improve, up 94.7% from 94.2% and a sustained increase from 93.9%.

The average 5 star rating this year was 4.79, an increase from 4.76 and 4.75. This sustained increase in patient satisfaction, given the increase in the number of responses, is an indicator of the high level of care and treatment we provide.

Our response rate continues to build, and we are continuing to towards a target of an average 10% Trust wide response rate.

Compliments

Services report compliments they receive on a quick and easy to use online Datix form (the same system we use for complaints and incident reporting). This is a way of sharing good practice and praise through our divisions and across the wider organisation. The system continues to be developed, following feedback from our staff to capture a variety of compliments, including people verbally saying, "thank you", as well as gestures such as flowers and cards. The table below shows the number of compliments received over time.

Year	2021/22	2022/23	2023/24	2024/25
Number of compliments received	3,794	4,522	4,036	4,904

These compliments are in addition to the positive feedback captured via the iWGC patient feedback tool.

Complaints

Services also use the online Datix system to log concerns that they have dealt with at a local level; referred to as 'Local Resolution', this method of responding to feedback continues to be supported by the Patient Experience Team. This is a helpful tool for measuring quality, before the escalation to a more formal complaint and is driven by our front-line services resolving concerns effectively, with support and training available from the Complaints Office and wider Learning and Development department.

The number of Formal Complaints received has reduced from 281 to 230, with the table below reporting the activity over time. This shows that whilst we received the highest number of Formal Complaints this year, it is important to consider this in terms of the number of patient contacts and the percentage of these contacts that result in a formal complaint being made:

Year	Number of Formal Complaints received	% of Patient Contacts
2024/25	230	0.032%
2023/24	281	0.030%
2022/23	240	0.043%
2021/22	231	0.049%
2020/21	213	0.038%

The Trust actively promotes feedback as part of 'Learning from Experience', which within the Complaints Office includes activity such as enquiries, services resolving concerns informally, working with other trusts on joint complaints, responding to the office of Members of Parliament who raise concerns on behalf of their constituents, complaints

raised via the Care Quality Commission and through advocacy services.

The Trust has maintained a 100% response rate to complaints within the agreed timescale and continues to monitor an internal target of 25 working days. Due to the complexity of some complaints and the availability of operational staff, meeting this internal target is not always possible.

Our complaint handling and response writing training available to staff continues to be delivered online over MS Teams and takes place on a regular basis (with a waiting list) across the different Divisions, in addition to bespoke, tailored training for specific teams which has taken place to staff groups and teams.

Our complaints process works alongside our Serious Incidents processes and Mortality Review Group (linking in as part of the Patient Safety Incident Response Framework; PSIRF) having a direct link to ensure that any complaint involving a patient death is reviewed. Weekly and monthly meetings with the Patient Safety Team take place to ensure that we are working effectively and identifying any themes or emerging patterns.

PALS

The Patient Advice and Liaison Service (PALS) provides a hybrid way of working; offering a mixture of remote, clinic and office-based working and this continues to work well with people contacting PALS (2,473 contacts compared to 1,542 the previous year). The wider Patient Experience Team supports PALS; however, they can ensure that they continue to offer a responsive, high-quality service. We said goodbye to our long-standing volunteer in March 2025 who has been a huge support for the service.

We continue to see how we can use Intelligent Automation (IA) to identify and respond to the increasingly high number of contacts (1,530 during the year across PALS and the Complaints) that the service receives that are for different NHS organisations and services.

The Patient Experience Team continue to offer the 'Message to a loved one' service that was set up as a response to the pandemic, enabling friends and family to send in messages, which are then sent on to patients on the ward. There continues to be positive feedback about this opportunity for people to stay in touch and stay connected to their life outside the hospital.

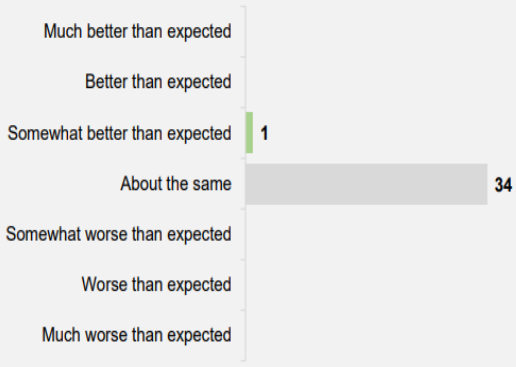
Annual Community Mental Health Team Survey Results

The Care Quality Commission published the benchmarking reports containing the results of the 2024 Community Mental Health Survey. The Mental Health Division will review and monitor actions through their Patient Safety and Quality meetings.

The highlights of the report are:

Comparison with other trusts

The **number of questions** at which your trust has performed better, worse, or about the same compared with all other trusts.

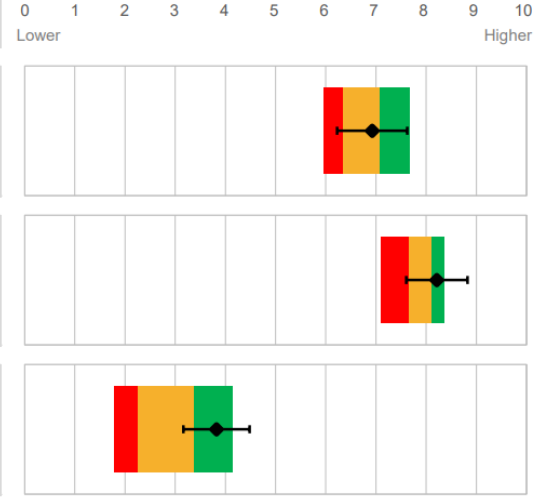


Comparison with last year's results

The **number of questions** at which your trust has performed statistically significantly better, significantly worse, or no different than your result from the previous year, 2024 vs 2023.

OVERALL - Benchmark Charts and Tables

		Lowest Scoring Trust	Lowest 20% Threshold	Highest 80% Threshold	Highest Scoring Trust	This Trust 2024 Number of Respondents	This Trust 2024 Score	This Trust 2024 RAG Rating
Q39	Overall, in the last 12 months, how was your experience of using the NHS mental health services?	5.96	6.34	7.06	7.67	246	6.92	
Q40	Overall, in the last 12 months, did you feel that you were treated with respect and dignity by NHS mental health services?	7.09	7.65	8.11	8.36	245	8.21	
Q41	Aside from this questionnaire, in the last 12 months, have you been asked by NHS mental health services to give your views on the quality of your care?	1.80	2.26	3.38	4.13	204	3.82	



Stakeholder relations

In 2023/24 the Trust commissioned the six Voluntary Community, Social Enterprise (VCSE) forums across Berkshire to run a series of community engagement events to

inform our Reducing Health Inequalities strategy, Mental Health, Equality, diversity and inclusion and VCSE strategy.

The Reducing Health Inequalities strategy has been published and can be found here: health-inequalities-strategy-bh861.pdf

In 2024/25 we completed a review of the community engagement and co-production work engaging with the VCSE forums and have commissioned Reading ACRE (Alliance for Cohesion and Race Equality) and Slough CVS (Council of Voluntary Services) to support community engagement work in developing the next version of the Trust's Health Inequalities Strategy, supporting the implementation of the Patient Carer Race Equality Framework (known as PCREF) that supports mental health Trusts build active anti-racist strategies and actions.

We have included an independent VCSE look at our PCREF action plan for 2025/26 and will continue to build the relationships with local communities and VCSE forums as key stakeholders.

The CommUNITY Anti-Racism forum continues to thrive and includes members across diverse communities and faiths. This forum supports and enables racialised community voices in our planning, service delivery and service transformation. We have established an Equity Partnership Group with responsibility to oversee the health inequalities, community engagement and equality, diversity and inclusion work. Our stakeholders form the core of this group.

Reducing health inequalities has been a key programme of work for us for a number of years. Throughout 2024/25 Berkshire Mind continued to run community engagement events with people with lived experience of being detained under the Mental Health Act and held events with staff who work with people that have been detained. The learning from Mind and our communities has informed the recommended actions for implementation. The findings and recommendations have been independently reviewed by the NHS Race Health Observatory, and we are jointly hosting a conference on the 1st of April 2025 to share the outcomes and commit to action.

Berkshire Healthcare continues to be a key partner in two Integrated Care Boards, Buckinghamshire, Oxfordshire and Berkshire West and Frimley Health and Care. The Trust is a member of the Frimley Health and Care Integrated Care Board and Assembly,

and a member of the Buckinghamshire, Oxfordshire, and Berkshire West Integrated Care Board. The Trust Chair regularly meets with our system and partner Trusts' Chairs and the Executive team have regular tripartite meetings with Buckinghamshire, Oxfordshire, and Berkshire West and Frimley Health and Care Integrated Care Board Executives.

The Trust are active contributors to both system and Place based plans and invite regular updates from System colleagues to the Trust Board and the Council of Governors. This work is supported by active engagement in a number of the system committees, forums and networks.

Both systems have a strong emphasis on Place based partnerships which the Trust actively supports. The purpose of these Place partnerships is to improve the health and wellbeing of the population served by the organisations within the Integrated Care System. As the provider of community physical and mental health services across Berkshire, we are key members of the Place-based partnerships with other key partners/stakeholders.

Working with our stakeholders is key to delivering integrated, person-centered care. This approach has supported delivery of:

- In partnership with Frimley Health NHS Foundation Trust and Royal Berkshire Hospital, providing community-based frailty virtual wards supported by a Community Urgent Crisis Response service that provides care for people in their own homes.
- Integrated Health and Social Care Teams, known as Multi-Disciplinary Teams (MDTs), delivering care and treatment in a more joined up way both in community settings and in Care Homes
- Working with Primary Care Network and other partners, including the voluntary and community sector delivering Mental Health Integrated Care Services, community based mental health services providing a stronger focus on prevention and maintaining well health
- Continuing the development of our electronic Shared Care record, known as Connected Care, to support proactive population health management approaches and provide the data for our developing provider collaboratives
- Continuing joint planning about our use of our buildings, a shared approach to workforce planning and development of our support workforce.
- We participate in and have constructive relationships with the six Health and Wellbeing Boards, Local Integration Groups and Unitary Authority Health Scrutiny arrangements and hold regular meetings with representatives from all six Health Watch Groups in Berkshire - which is coordinated by our Patient Experience Team.
- In January 2025, guidance on Neighbourhood Health was released that aims to "create healthier communities, helping people of all ages live healthy, active and independent lives for as long as possible while improving their experience

of health and social care" through better connecting health services and health and social care services and optimising health and care resource.

- The guidance reiterates the three left shifts as set out in Lord Darzi's Independent Investigation of the NHS in England Report, and states that these will be at the core of the government's health mission:
    - **from hospital to community** – providing better care close to or in people's own homes, helping them to maintain their independence for as long as possible, only using hospitals when it is clinically necessary for their care
    - **from treatment to prevention** – promoting health literacy, supporting early intervention and reducing health deterioration or avoidable exacerbations of ill health
    - **from analogue to digital** – greater use of digital infrastructure and solutions to improve care

The Trust is working with stakeholders across Berkshire including primary care and VCSE to build integrated team working at neighbourhood level.

Remuneration Report

Chair and Non-Executive Director Remuneration

The remuneration and expenses of the Chair and Non-Executive Directors are determined by the Council of Governors on the recommendation of the Council of Governors' Appointments and Remuneration Committee. The Committee takes account of relevant market data, including the results of the NHS Providers' Chairs and Non-Executive Directors Annual Remuneration Survey. The Council of Governors' Appointments and Remuneration Committee comprises of four Governors and is chaired by the Trust Chair. When the Committee is reviewing issues pertaining to the Trust Chair, the Lead Governor chairs the meeting, and the Trust Chair is not present.
The remuneration of Non-Executive Directors is comprised solely of their annual fee.

The Council of Governors' Appointment and Remuneration met in July 2019 and compared the current level of Non-Executive Director remuneration with other local NHS foundation trusts and with the benchmarking data provided by NHS Providers. The Committee agreed to remove the special responsibility allowances for the Vice Chair, the Senior Independent Director, and the Chair of the Audit Committee.

The Council of Governors' Appointments and Remuneration Committee met on 5 November 2024 and reviewed the Chair and Non-Executive Directors' remuneration. The Committee took account of national benchmarking data, and the NHS Agenda for Change and Very Senior Managers pay awards for 2024-25 and agreed to recommend to the Council of Governors that the Chair and the Non-Executive Directors receive a 5% inflationary uplift backdated to 1 April 2024. The Council of Governors approved the recommendation at its meeting on 4 December 2024.

Senior Managers Remuneration

Remuneration of the Trust's 'senior managers' (the Chief Executive, Executive Directors and Very Senior Managers (VSMs) is determined by the Trust Board's Appointments and Remuneration Committee. The Trust Board's Appointments and Remuneration Committee comprises the Trust Chair and all the Non-Executive Directors and is chaired by Mark Day, Non-Executive Director. The Chief Executive attends the meetings except when the Committee is discussing his terms and conditions and remuneration. The meeting is supported by the Director of People and the Company Secretary.

The Committee does not routinely apply inflationary uplifts or increases and only applies uplifts of any kind where this is thought to be justified by the context. The Committee's main aim is to ensure that Executive and Very Senior Manager remuneration is set at an appropriate level to ensure good value for money, whilst enabling the Trust to attract and retain high quality Directors. Executive Directors and Very Senior Manager remuneration does not currently include a specific performance-related element.

Senior Managers' Remuneration Policy

The Trust's Senior Managers Remuneration Policy as developed by the Appointments and Remuneration Committee is set out below.

The Trust's policy reflects NHS England's guidance on Very Senior Managers Pay and the remuneration section of the Code of Governance for NHS Provider Trusts. The Committee also identified the following key considerations for the remuneration policy:

- **Trust's Values and Behaviours** - to reflect the values of the organisation and ensure the setting of salaries and the annual awards are fair, consistent and recognise not only the contribution of the individual but also the overall performance of the Trust.
- **Trust's Equalities and Diversity Strategy** - The Committee should ensure any changes to senior salaries consider any gender or unconscious bias that may occur. Pay decisions must always consider experience, competence, skills, responsibility, accountability and performance.
- **Hays Directors Pay and Reward Review December 2018** - Following the independent review, it was agreed that the role of the Chief Operating Officer and the Director of Nursing and Therapies are comparable in terms of accountabilities and responsibilities, and this should be reflected when setting the remuneration for the Director of Nursing and Therapies.

New Executives

The Chair and the Chief Executive would determine the salaries for new starters. This would take account of:

- NHS England's and other external salary benchmarking data
- Market conditions, for example, reviewing the number of quality candidates applying and the salary expectations
- Review of experience at Very Senior Manager or equivalent level
- Consideration of the gender pay gap and any unconscious bias

Annual Pay Review of Executives

The Committee agreed that the annual pay review for Executive Directors and Very Senior Managers would take account of:

- The Trust's performance against targets set at the start of the annual performance cycle; the outcome of the Care Quality Commission's Well Led assessment; financial stability; and an assessment against national agreed contracts and performance benchmark data for comparable organisations
- NHS England and NHS Provider's national salary benchmark data
- Local recruitment markets (for example, local NHS Trusts' ability to recruit and staff turnover etc)
- The annual award for all Agenda for Change staff
- A review performance of the individual:
    - If performance is not satisfactory, the individual will not be considered for a pay award
    - Base pay position against the NHS England's benchmark will take place, if performance is 'good' then consideration of a consolidated award would take place
- In addition, for individuals to be eligible for a pay award:
    - They must have had a satisfactory appraisal in the last 12 months
    - Their performance and/or capability is not being formally managed
    - They do not have a live formal disciplinary sanction on their record
    - They must be up to date with all their statutory and mandatory training
    - If they are a line manager, the appraisals for all their team are completed
    - If there is something beyond their control which has stopped them from achieving any of the above, then this will be taken into consideration
- Review of exceptional performance:
    - If the individual earns above the Prime Minister's salary, the Chair will refer the case to NHS England for review and comment prior to submission to the Department of Health and Social Care for the Secretary of State's opinion
    - Gender pay gap and unconscious bias consideration – the Committee will assure itself that no pay discrimination occurs when determining base pay or performance awards. The Committee will use evidence and test the reliability of that evidence when making decisions. Pay decisions will be

based on evidence, experience, competence, skills, responsibility, accountability, and performance.

- The Committee recognises that salary uplifts are not automatic and are dependent on the performance of the Trust and on the performance of the individual being satisfactory
- The Committee retains the right not to award any salary uplifts.

Where any senior manager is paid above £150,000 annum, the Appointments and Remuneration Committee will have satisfied itself that the actual level of remuneration paid is reflective of the individual post holder's level of responsibility and performance and that the remuneration has been considered against appropriate benchmark information, local recruitment market conditions and the need to provide a reward package that ensure the recruitment and retention of high calibre senior executives.

Executive and Very Senior Manager contracts provide for a period of notice of six months on the part of the Trust as agreed by the Appointments and Remuneration Committee. A senior manager may suffer loss of office in a number of situations and in such cases the six-month notice period normally applies, however, the Trust can, at its discretion, choose to make payment in lieu of all or part of the notice period.

Where loss of office is due to circumstances where summary dismissal applies, such as gross misconduct or serious performance failure for example, no notice period would apply. If loss of office was due to redundancy, then the notice period would apply, as would any redundancy provisions applying generally in the NHS at the point in time; the principle being that very senior managers would be treated neither no less nor no more favourably than other Trust staff.

Annual Statement on Remuneration

In December 2018, the Trust commissioned Hays Executive to undertake a review of Executive pay and rewards to provide an independent external view of the current relevant market pay and reward data, taking into consideration of the health sector and direct peer organisations. The review concluded that the remuneration of Executives and Very Senior Managers was broadly in line with other comparable organisations.

The Hays review identified a small gender pay gap in relation to the Director of Nursing role which was traditionally a female role and therefore there was a risk that any national benchmarking data perpetuated the gender pay gap.

The Committee addressed the gender pay gap as part of the Director of Nursing and Therapies recruitment process which concluded in June 2019.

Gender pay reporting occurs each March. Further information about the Trust's gender pay gap can be obtained from Trust's website at: https://www.berkshirehealthcare.nhs.uk/about-us/equality-diversity-and-inclusion/

The Committee considers the pay and conditions of other employees, for example, the Agenda for Change pay settlement and the current pay settlement for senior civil servants when considering remuneration policy but does not actively consult with employees.

During 2024-25, the Trust did not operate a performance related element to very senior managers' remuneration.

At its meeting on 12 November 2024, the Appointments and Remuneration Committee reviewed the Trust's Remuneration Policy in relation to the practice of awarding non-consolidated pay awards for salaries at or above NHS England's upper quartile benchmarked salaries.

The Appointments and Remuneration Committee noted that NHS England's benchmarked salaries were based on 2016 information and therefore was significantly out of date. It was also noted that NHS England's letter to Trusts recommended a 5% consolidated pay award for staff on very senior manager contracts.

In the previous year, the Appointments and Remuneration Committee had agreed to amend the Trust's Remuneration Policy and to award consolidated pay awards (individuals could still opt to receive a non-consolidated pay award if that was their personal preference). The Appointments and Remuneration Committee also agreed that the accrued non-consolidated salary would be consolidated each year over the next three years.

After considering NHS England's guidance on very senior managers' pay, NHS England's letter to Trusts dated 19 October 2023 which recommended a 5% consolidated pay award for staff on very senior manager contract, the Appointments and Remuneration Committee agreed to award a 5% consolidated pay award for all staff on very senior manager contracts (that is, the Chief Executive, Executive Directors, Chief Information Officer, Director of People and Director of Finance) backdated to 1 April 2024.

The Appointments and Remuneration Committee reviewed the remuneration of the Chief Financial Officer (appointed in November 2021) and the Chief Operating Officer (appointed in May 2022) and noted that their starting salaries had reflected that this was their first board appointment and therefore they had both been placed at the lower quartile of the benchmarked salary scale.

The Appointments and Remuneration Committee agreed to award an additional 5% consolidated salary increase per annum salary uplift to both the Chief Financial Officer and the Chief Operating Officer for 2024-25.

The only non-cash element of the most senior managers' remuneration packages is pension-related benefits accrued under the NHS Pension Scheme. Contributions are made by both the employer and employee in accordance with the rules of the Scheme.

All senior managers are employed on service contracts and are substantive Trust employees. Their contracts are open-ended employment contracts which can be terminated by the Trust with six months' notice. Other Trust staff are covered by the terms and conditions of the national NHS Agenda for Change provisions.

All other Trust staff are covered by the national NHS Agenda for Change and Medical and Dental pay and conditions.

The Trust Board sets the organisation's corporate objectives annually and these are used as the basis for developing personal objectives for the Chief Executive and Executive Directors. Performance is closely monitored throughout the year and in the context of annual appraisal.

Mark Day
Chair, Appointments and Remuneration Committee

Details of remuneration and pension benefits for Directors and senior managers are set out in the tables below:

Salaries and Allowances (*the following information is subject to audit)*

				2024/25						2023/24					
Name	Title	From	To	Salary and fees (in bands of £5,000) £000s	Taxable benefits (total to the nearest £100) £00s	Annual performance related bonuses (in bands of £5,000) £000s	Long-term performance related bonuses (in bands of £5,000) £000s	Pension related benefits (in bands of £2,500) £000s	Total (in bands of £5,000) £000s	Salary and fees (in bands of £5,000) £000s	Taxable benefits (total to the nearest £100) £00s	Annual performance related bonuses (in bands of £5,000) £000s	Long-term performance related bonuses (in bands of £5,000) £000s	Pension related benefits (in bands of £2,500) £000s	Total (in bands of £5,000) £000s
Executive Directors															
Tehmeena Ajmal [1]	Chief Operating Officer	01/04/2024	14/03/2025	150 - 155	0	0	0	75.0 - 77.5	225 - 230	145 - 150	0	0	0	-	145 - 150
Julian Emms	Chief Executive	01/04/2024	31/03/2025	240 - 245	0	0	0	85.0 - 87.5	330 - 335	230 - 235	0	0	0	-	230 - 235
Deborah Fulton	Director of Nursing & Therapies	01/04/2024	31/03/2025	170 - 175	0	0	0	67.5 - 70.0	235 - 240	160 - 165	0	0	0	200.0 - 202.5	360 - 365
Alex Gild	Deputy Chief Executive	01/04/2024	31/03/2025	185 - 190	0	0	0	130.0 - 132.5	315 - 320	185 - 190	0	0	0	-	185 - 190
Paul Gray	Chief Financial Officer	01/04/2024	31/03/2025	165 - 170	0	0	0	35.0 - 37.5	200 - 205	145 - 150	0	0	0	130.0 - 132.5	275 - 280
Dr Minocher Irani [2]	Medical Director	01/04/2024	28/03/2025	215 - 220	0	0	0	0.0 - 2.5	215 - 220	205 - 210	0	0	0	-	205 - 210
Dr Tolulope Olusoga [3]	Medical Director	29/03/2025	31/03/2025	0 - 5	0	0	0	147.5 - 150.0	150 - 155	-	-	-	-	-	-
Theresa Wyles [4]	Interim Chief Operating Officer	17/03/2025	31/03/2025	5 - 10	0	0	0	97.5 - 100.0	100 - 105	-	-	-	-	-	-
Non Executive Directors															
Rebecca Burford	Non Executive Director	01/07/2023	31/03/2025	15 - 20	0	0	0	-	15 - 20	10 - 15	0	0	0	-	10 - 15
Naomi Coxwell	Non Executive Director	13/12/2017	31/03/2025	15 - 20	0	0	0	-	15 - 20	15 - 20	0	0	0	-	15 - 20
Mark Day	Non Executive Director	01/04/2017	31/03/2025	15 - 20	0	0	0	-	15 - 20	15 - 20	0	0	0	-	15 - 20
Martin Earwicker	Chair	01/04/2017	31/03/2025	50 - 55	0	0	0	-	50 - 55	45 - 50	0	0	0	-	45 - 50
Aileen Feeney	Non Executive Director	01/11/2019	31/03/2025	15 - 20	0	0	0	-	15 - 20	15 - 20	0	0	0	-	15 - 20
Rajiv Gatha	Non Executive Director	01/10/2021	31/03/2025	15 - 20	0	0	0	-	15 - 20	15 - 20	0	0	0	-	15 - 20
Dr Sally Glen	Non Executive Director	01/06/2022	31/03/2025	15 - 20	0	0	0	-	15 - 20	15 - 20	0	0	0	-	15 - 20
Nighat Mian	Non Executive Director	01/06/2015	30/06/2023	-	-	-	-	-	-	0 - 5	0	0	0	-	0 - 5

(1) Tehmeena Ajmal resigned from the position of Chief Operating Officer and ceased working in their post from the 14th March 2025

(2) Dr Minocher Irani resigned from the position of Medical Director and terminated from their post on the 28th March 2025

(3) Dr Tolulope Olusoga was appointed Medical Director as replacement for Dr Minocher Irani and commenced in post from the 29th March 2025

(4) Thersa Wyles was appointed Interim Chief Operating Officer and commenced in post from the 17th March 2025

No members of the Trust Board received an annual or long-term performance related bonus in 2024/25 (2023/24 £nil)

Pension Related Benefits are caclulated in accordance with the Finance Act 2004. This is commonly referred to as the "HMRC method". The amount included is based on the increase in the director's accrued pension in the year. This will generally take into account an additional year of service together with any increases in pensionable pay. This amount is then multiplied by 20 to calculate the amount to be included in the Remuneration Report.

Pensions (the following information is subject to audit)

				(a)	(b)	(c)	(d)	(e)	(f)	(g)	(h)
Name	**Title**	**From**	**To**	Real increase in pension at pensionable age (bands of £2,500) £,000s	Real increase in pension lump sum at aged 60 (bands of £2,500) £,000s	Total accrued pension at pensionable age at 31 March 2025 (bands of £5,000) £,000s	Lump sum at pensionable age related to accrued pension at 31 March 2025 £,000s	Cash Equivalent Transfer Value at 1 April 2024 £,000s	Real increase in Cash Equivalent Transfer Value £,000s	Cash Equivalent Transfer Value at 31 March 2025 £,000s	Employer's contribution to stakeholder pension £,000s
Executive Directors											
Tehmeena Ajmal [1]	Chief Operating Officer	01/04/2024	14/03/2025	2.5 - 5.0	0.0 - 2.5	55 - 60	150 - 155	1,259	80	1,436	0
Julian Emms	Chief Executive	01/04/2024	31/03/2025	5.0 - 7.5	2.5 - 5.0	95 - 100	250 - 255	2,100	111	2,381	0
Deborah Fulton	Director of Nursing & Therapie	01/04/2024	31/03/2025	2.5 - 5.0	0.0 - 2.5	65 - 70	55 - 60	1,044	70	1,205	0
Alex Gild	Deputy Chief Executive	01/04/2024	31/03/2025	5.0 - 7.5	10.0 - 12.5	60 - 65	165 - 170	1,170	133	1,403	0
Paul Gray [2]	Chief Financial Officer	01/04/2024	31/03/2025	2.5 - 5.0	0.0 - 2.5	45 - 50	125 - 130	906	0 [3]	853	0
Dr Minocher Irani	Medical Director	01/04/2024	28/03/2025	0.0 - 2.5	0.0 - 2.5	90 - 95	235 - 240	2,130	0 [3]	561	0
Dr Tolulope Olusoga	Medical Director	29/03/2025	31/03/2025	0.0 - 2.5	0.0 - 2.5	40 - 45	105 - 110	718	1	909	0
Theresa Wyles	Interim Chief Operating Officer	17/03/2025	31/03/2025	0.0 - 2.5	0.0 - 2.5	35 - 40	95 - 100	705	0 [3]	866	0

(1) Tehmeena Ajmal opted out of the NHS Pension Scheme on the 1st August 2024 and then opted back in on the 1st February 2025
(2) Paul Gray opted out of the NHS Pension Scheme from the 1st January 2025
(3) Where there is a negative real increase, the reported value is returned as £0

As Non-Executive Director members do not receive pensionable remuneration, there will be no entries in respect of pensions for Non-Executive members.

Cash Equivalent Transfer Values

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies. The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Following the government's announcement that all public sector pension schemes will be required to provide the same indexation on the Guaranteed Minimum Pension (GMP) as on the remainder of the pension, the NHSPS has revised its method to calculate the CETV values. The real increase in CETV will therefore be impacted as it will include any increase in CETV due to the change in GMP methodology
Cash equivalent transfer value (CETV) figures are calculated using the guidance on discount rates for calculating unfunded public service contribution rates that was extant on 31 March 2023. HM Treasury published updated guidance on 27 April 2023; this guidance is used in the calculation of 2024/25 CETV figures.

Real Increase in CETV

This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement) and uses common market valuation factors for the start and end of the period. Where a member has a CETV of £0 the member has reached Normal Retirement Age.

McCloud Judgement

The McCloud judgment' was a Supreme Court case in which the Court ruled that the additional final salary protections that were given to certain older members of public service pension schemes were age discriminatory. The judgement applies to all public service pension schemes, including the Local Government Pension Scheme ('LGPS'), and the inequalities identified must be remedied.

Due to the NHS Pensions "Roll Back" relating to the McCloud remedy, some of the above staff have had their pensions adjusted by moving 7 years of the 2015 Pension back into either the 1995 or 2008 sections of the pension, thus giving significant increases in that pension and a significant reduction in the 2015 figures in comparison to last year's figures quoted.

Tehmeena Ajmal, Julian Emms, Alex Gild, and Dr Minocher Irani are affected by the Public Service Pensions Remedy and their membership between 1 April 2015 and 31 March 2022 was moved back into the 1995/2008 Scheme on 1 October 2023.

Fair Pay Disclosures

NHS foundation trusts are required to disclose the relationship between the remuneration of the highest-paid director in their organisation and the lower quartile, median and upper quartile remuneration of the organisation's workforce.

The banded remuneration of the highest-paid director in the organisation in the financial year 2024/25 was £240K-£245K (2023/24 was £230K-£235K). This is a change between the years of 5% (2023/24, 5%).

Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind, but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

For employees of the Trust as a whole, the range of remuneration in 2024/25 was from £0 - 5K to £300K - £305K (2023/24, £0 - 5K to £295K - £300K).

The percentage change in average employee remuneration (based on total for all employees on an annualised basis divided by full time equivalent number of employees) between years is 2.58% (2023/24, 8.79%)

Three (3) employees received remuneration more than the highest-paid director in 2024/25 (2023/24, 2)

The remuneration of the employee at the 25th percentile, median and 75th percentile is set out below. The pay ratio shows the relationship between the total pay and benefits of the highest paid director (excluding pension benefits) and each point in the remuneration range for the organisation's workforce.

2024/25	**25th Percentile**	**Median**	**75th Percentile**
Salary Component of Pay	£240K - £245K	£240K - £245K	£240K - £245K
Total pay and benefits excluding pension benefits	£30,570	£41,655	£54,208
Pay and benefits excluding pension: pay ratio for highest paid director	7.95 : 1	5.83 : 1	4.48 : 1

2023/24	**25th Percentile**	**Median**	**75th Percentile**
Salary Component of Pay	£230K - £235K	£230K - £235K	£230K - £235K

2023/24	25th Percentile	Median	75th Percentile
Total pay and benefits excluding pension benefits	£29,475	£39,598	£52,030
Pay and benefits excluding pension: pay ratio for highest paid director	7.89 : 1	5.87 : 1	4.47 : 1

The change in the Median ratio from 5.87:1 to 5.83:1 is arising from the following factors:

- The composition of the general workforce has changed, with a decrease in temporary staffing (Bank and Agency) to £31.7m in 2024/25 (2023/24: £34.5m). Bank and agency costs as a percentage of total pay was 10.2% in 2024/25 compared to 9.2% in 2023/24.
- The median national pay award for NHS staff in 2024/25 was 5.5% for all staff. The uplift in annual salary for the highest paid Executive Director from 2023/24 to 2024/25 was 5% (2022/23 to 2024/25, 5%) against basic salary.
- Some staff will have been entitled to receive an increment for progression through the Agenda for Change pay band which would increase their basic salary beyond the 5% national pay award.

The Trust believes the median pay ratio for the relevant financial year is consistent with the pay, reward and progression policies for the entity's employees taken as a whole.

Julian Emms
Chief Executive
18 June 2025

Our last three-year Trust People Strategy and the Equality Diversity and Inclusion (EDI) Strategy have concluded with their key success measures achieved. However, further work is needed to ensure that the Trust remains a great place to give and receive care now and in the future. After reviewing the outcomes of both strategies, the Trust recognised the need to align our EDI ambitions under one clear framework which articulates our ambitions around equity and inclusion for both patients and staff. This framework aims to enhance the experience of the Trust for all stakeholders.

Our new People and Culture Strategy builds on the success of our last People Strategy and continues our commitment to equity and inclusion for staff, in line with the NHS People Promise. The new strategy was developed after extensive engagement with staff through questionnaires, listening events, and feedback from staff representatives and networks. The strategy identifies four workforce risks and translates these into four areas of focus, each with a supporting programme of work as illustrated in the diagram overleaf.

As described in the graphic above we have identified four key workforce challenges to address this year:

Attract - The Supply of Clinical Staff

Our goal is to attract a diverse and talented workforce that can meet the current and future needs of the Trust and the diverse population we serve by developing comprehensive workforce plans and tailored and inclusive talent attraction strategies.

We are operating in an environment of specific workforce shortages in key clinical areas. Student numbers are declining for many clinical degrees and whilst we have seen an increase in registrations for mental health nursing degrees, nationally, the student numbers still do not match the number of leavers from these roles.

The Trust has grown its workforce from 5,218 in March 2024 to 5,495 by mid-March 2025, a 5% increase. This growth matches financial plans and meets the rise in commissioned services. Our candidate attraction and clinical education teams have successfully recruited more staff, and workforce planning analysis has pinpointed where efforts are needed most. These actions have reduced temporary staffing compared to last year, keeping us within NHS England's agency expenditure ceiling.

Retain

We aim to sustain a positive and supportive working culture that fosters a culture where people want to work and stay. We will address disparities in career progression

and offer fair and equitable career pathways that support all of our staff to progress in their careers with us.

High Turnover of Staff

After high turnover in 2022, our retention programme has led to a steady decline in turnover across all services, staff groups, and nearly all bands. The Trust now has its lowest turnover rate in recent years, and our turnover rate has declined faster than our surrounding trusts. We are focusing our efforts now on identifying services or groups where turnover is higher than the trust average to understand why and support teams to address issues that may cause this.

Inequalities in Staff Progression

A key priority is to reduce inequalities in staff progression for those with protected characteristics. Our Workforce Race Equality and Disability (WRES & WDES) data, staff survey results, and ethnicity pay gap report, still highlights inequity in progression for our ethnically diverse staff.

Berkshire Healthcare uses a talent review process for its senior leadership team (SLT) to enhance succession planning. This strategic approach helps identify and develop successors for roles at or just below Board level. Therefore, we have credible internal candidates for most senior vacancies and have promoted many of our own colleagues to Board and SLT positions. Key to the delivery of this aim is the development of a talent management approach that identifies and nurtures the potential of our diverse workforce below the SLT and provides pathways for equitable and fair career progression up through and into SLT/Board roles.

In 2024, we implemented talent questions for our mid-year review conversations to foster meaningful career discussions that help staff consider their development plans at the Trust. These questions encourage employees to reflect on their career pathways and identify those interested in career progression now or in the near future. We have created and delivered various supporting materials and learning sessions to maximise the effectiveness of these conversations for both staff and their managers. The data gathered from mid-year reviews will help to identify talent pools within specific leadership tiers, enabling a more strategic and tailored approach to developing and prioritising leadership initiatives based on appropriate competencies. Establishing talent pools allows the Trust to better understand its potential pool of candidates for future roles and identify any significant gaps. This information will support ongoing efforts to ensure staff have opportunities for internal progression.

To address the disparity in ethnicity for roles at Agenda for Change pay Band 8b and above, job descriptions have been revised to make them fairer and more inclusive. Guaranteed interviews are offered to ethnically diverse candidates who meet the essential criteria for these senior roles. Additionally, a review process has been implemented for all interview decisions at Agenda for Change pay Band 8b and above where a white applicant is selected as the preferred candidate to ensure fairness and

equity in the interview process.

Colleagues in both clinical and non-clinical Agenda for Change pay Bands 5 to 8a roles have been given the opportunity also to attend a tailored leadership programme to address disparities in leadership representation.

We have started to explore our internal promotion data, which shows there are still inequalities present as our ethnically diverse colleagues apply for more jobs, but our White colleagues have a higher success rate securing jobs. However, the data shows that the promotion rate between Agenda for Change pay Bands 2 to 8b for our ethnically diverse colleagues is higher than that of our white colleagues. This peaks at Band 5 and then starts to drop off with no promotions for our ethnically diverse colleagues at 8c and above. More work is needed to understand this better, and we will carry this forward into 2025/26.

Disability is slightly more varied, Agenda for Change Pay Bands 2-4, 6 and 7 are more positive in terms of promotion rates for disabled staff but like ethnically diverse colleagues, no one who declared a disability was promoted past band 8b.

Develop

We want to support the continuous professional development and career aspirations of our staff so that we have a workforce with the skills, confidence, knowledge and competencies to deliver professional excellence and high-quality care

With declining university applications for Nursing and Allied Health Professional programmes, apprenticeships are key to building our future workforce. The Trust has focused on supporting staff through apprenticeships to address national clinical shortages and, importantly, as part of our commitment to widening participation by providing career pathways and development for our staff. Functional skills support is also enabling many of our support workers to pursue clinical apprenticeships and join the NHS workforce. Currently, 83 learners are enrolled in clinical apprenticeships leading to roles such as registered nurses, occupational therapists, and speech and language therapists. We expect 39 apprentices to qualify in 2024/25, 38 in 2025/26, and more by 2026-2028. Data shows that up to 87% of staff supported through an apprenticeship remain with the Trust for at least 12 months after completing the programme.

Our T-level programme supported 11 candidates successfully for a third year. The placement programme, recommended by 93% of students, supports up to 500 trainees annually across various professions. In 2024, we supported 70 final-year candidates who were ready to recruit at the end of their course.

Training and Clinical Education

The Trust ensures that all its staff have the appropriate skills, training and support for

their roles through our recruitment processes and ongoing training programmes. This year, we have focused on reviewing the essential skills training we require of our staff to ensure that this remains appropriate for our changing demands. We have also launched the first phase of online Oliver McGowan training (learning disability and autism awareness training) for our staff and have a compliance rate of over 86% for completion.

We are facing increasing training demands, reduced continuous professional development (CPD) funds, and other educational resource constraints year on year. To address this challenge, we have created several new e-learning programmes to replace some of the face-to-face training and have released up to 500 clinician hours where it is safe to do so.

We have also developed a complex clinical communication programme that saved us £30,000 in CPD spend. A new CPD funding process has been co-designed with the Director of Nursing and Therapies and Operational Directors to ensure optimisation of funding usage. To promote equity of training access, our Clinical Education team is working with the Equality, Diversity, and Inclusion team to create a CPD dashboard to monitor funding allocation data and ensure access to training and development opportunities are allocated equitably to our staff.

Coaching

An internally accredited network of coaches has been established, offering a package that includes coach supervision and CPD. This ensures the quality of the coaching available to all Trust colleagues for both 1:1 and team coaching.

Leadership development

Our management and leadership programmes, Essential Knowledge for Managers (EKM) and Leading for Impact, have been refined to align with Trust behaviours and compassionate leadership principles. New managers are contacted within 4 weeks of joining and provided with development opportunities, including EKM. The Manager Support Network (MSN) offers skill development and learning for all managers and leaders. We are launching a set of leadership competencies which we will align with development offerings like apprenticeships and Leadership Academy programmes.

For individuals seeking to take a first career move, we offer the 'Reaching My Potential' course. This course is available to anyone aiming to develop within their existing role, contemplating a lateral move, or aspiring to progress into a management position.

Improve

We will promote a culture of continuous learning and improvement and encourage research and innovation in the way that we work and how we deliver patient care. We will enhance our people services by developing new ways of working that enhance productivity, efficiency, and flexibility to release staff capacity to focus on value

adding activities and improve patient care

Staff Experience

We recognise that a positive staff experience contributes to improved patient outcomes and that fostering a culture of learning and improvement is essential for maintaining high-quality care. Central to this is the principle of equity and inclusion, as we understand that genuinely including individuals is crucial for creating a positive sense of belonging, enhancing staff engagement and experience, and ultimately aiding in the attraction and retention of our staff. Our principal measure of staff experience is our staff engagement score in the national NHS Staff Survey. We are pleased that this year we scored 7.5 for staff engagement, which was the highest score in our comparator group.

We continue to address the broader issues contributing to poor staff experiences, including instances of physical and verbal abuse and bullying. This year, we conducted a self-assessment based on the newly revised national violence prevention and reduction standards. We created an action plan that included developing a post-abuse guidance toolkit for managers and initiating a project to investigate the causes of bullying and harassment as well as potential countermeasures.

We continued our work in relation to the Sexual Safety Charter and have identified necessary actions and areas for improvement, including launching a learning package and policy for staff. We also signed the Employers Initiative on Domestic Abuse (EIDA) Charter committing to supporting our colleagues who suffer from domestic abuse. On the back of this we introduced a staff policy and delivered sessions for managers and all staff in creating awareness and signposting for support.

For a comprehensive overview of how we have enhanced the staff experience this year, please refer to the Equality, Diversity and Inclusion section.

Talent and Leadership

We are pleased to have scored highly in the leadership theme of the staff survey. We have increased our scores for two years running, which coincides with launching our leadership and management development strategy and re-launching our leadership development provision which we paused during the COVID-19 pandemic. We scored 7.7 for 'compassionate leadership' compared to 7.5 which was the average for Trusts' in our comparator group. We scored 7.6 for 'Line management' compared to 7.4 which was the average for Trusts', our comparator group.

Staff experience and engagement

For the last several years, staff engagement has been a key success measure for Berkshire Healthcare. We recognise the importance of high levels of staff engagement as a direct contributor to, not only patient care, patient experience and high-quality clinical outcomes, but also to the ability to recruit and retain our workforce. We are

pleased that this year our staff engagement was 7.5 - one of the highest in the country and top of our comparator group. For the fifth year running We have also remained the top scoring trust within our peer groups for recommending the organisation as a place to work.

Our approach to staff engagement is multi-faceted. We actively use the results from the national NHS Staff Survey as well as quarterly pulse surveys. We host a monthly all-staff briefing where anyone can ask questions and they are either answered directly or in a "you said, we did" section the following month. Our 'Bright Ideas' programme enables everyone to submit an idea that could improve staff or patient experience for consideration by those able to implement those ideas.

This year, we conducted a series of 'Big Conversations' as part of our 'Listening into Action' programme. This approach is designed to engage and empower our staff by ensuring they have ownership and a voice in our organisational activities and improvement efforts when addressing widespread challenges. It provides a framework where incremental steps can be initiated starting with one significant 'Big Conversation.' Listening to feedback from these sessions is crucial in guiding future enhancements and changes. The title 'Listening into Action' was derived from this concept; we listen to you, and your feedback drives the actions we undertake.

Staff engagement is also driven through Our Quality Improvement (QI) approach to problem solving and process improvement. Our QI methodology is well embedded in the Trust and enables us to involve teams in finding solutions to the problems they face at work.

Our goal is to maintain and improve our high levels of staff engagement, however we recognise that there are some groups of staff that have a significantly worse experience than their colleagues. Our priority therefore is to address this inequality in experience and our anti-racism action plan is critical to addressing this. For more information on this work, see the Equality, Diversity and Inclusion Section of this report.

National NHS staff survey

The National NHS staff survey is conducted annually and our response rate to the 2024 survey was 64% (2023: 67%), which remains 10% above the average for our comparator group. The number of staff participating in the Staff Survey stayed consistent this year, although our overall percentage decreased. This meant 3,305 people (compared to 3,291 last year) took the time to tell us what it feels like to work at Berkshire Healthcare.

Since 2021 the national NHS Staff Survey questions align to the seven elements of the NHS 'People Promise' and retains the two previous themes of engagement and morale. All indicators are based on a score out of 10 for specific questions with the indicator score being the average of those.

Scores for each of the elements and themes together with that of the average for the survey benchmarking group (Mental Health & Learning Disability and Mental Health, Learning Disability & Community Trusts) are presented below.

Indicators ('People Promise' elements and themes)	**2024**		**2023**		**2022**	
	Trust score	Benchmarking Group (average)	Trust score	Benchmarking Group (average)	Trust score	Benchmarking Group (average)
People Promise:						
We are compassionate and inclusive	7.87	7.55	7.80	7.53	7.75	7.54
We are recognised and rewarded	6.69	6.35	6.60	6.41	6.46	6.29
We each have a voice that counts	7.31	6.94	7.27	7.01	7.27	6.97
We are safe and healthy	6.69	6.40	6.56	6.38	6.45	6.24
We are always learning	6.33	5.93	6.33	5.93	6.12	5.72
We work flexibly	7.15	6.83	7.09	6.84	6.97	6.75
We are a team	7.41	7.15	7.34	7.18	7.27	7.10
Staff engagement	7.49	7.07	7.45	7.11	7.44	7.05
Morale	6.56	6.20	6.42	6.17	6.27	6.04

We are delighted that our staff have given us the top staff engagement score for any combined community and mental health trust at 7.5 and that we have remained the top scoring trust within our peer groups for recommending the organisation as a place to work for the fifth year running.

This year's national NHS Staff Survey results show 15 statistically significant increases and no statistically significant declines. The questions addressed various sub-scores, indicating improvements across different areas. Additionally, there were 25 questions where scores were the highest within our comparator group. All the people promise elements/themes also scored above the comparator average, presenting a consistent picture.

There were no statistically significant declines in questions this year, so we have reviewed the progress on the three questions from last year. This can be seen in the graph below as well as the trend data over the past 5* years.

*Only four years of data available for question 20b

Despite positive overall results, we need to address two key areas for improvement. First, scores vary widely between services and teams, meaning not all teams share the same positive experience. Second, staff with protected characteristics still face differentials in their experiences, particularly for our disabled staff.

Future priorities and targets

Our priority areas for the coming year(s) reflect the key areas for improvement indicated above – a focus on service/team level outcomes and supporting those with the lowest scores and working on our equality, diversity and inclusion programmes to ensure that Berkshire Healthcare is a great place to give care – for everyone.

To enhance service and team-level outcomes, we will identify the teams within the trust with the lowest staff engagement scores and address these issues through collaboration between operational teams and Human Resources Business Partners. The actions will be tailored based on a comprehensive analysis of the wider data set to pinpoint the factors contributing to lower scores. Progress will be tracked through regular reports from Human Resources People Partners and communicated back to staff through our annual "You Said, We Did" campaign.

The disparities in experiences among staff with protected characteristics are addressed through our People Strategy which encompasses our anti racism, neurodiversity and sexual safety action plans. Further details about these programmes and their monitoring can be found in the Equality, diversity and inclusion sections.

Pay Gap Reporting

In addition to statutory gender pay gap reporting, we voluntarily introduced ethnicity and disability pay gap reporting two years ago. Pay gap data is derived from the hourly wages of our colleagues as of the snapshot date of 31st March. Pay gaps represent persistent, unacceptable differences between mean and median rates of pay, with complex causes influenced by social issues. We use the Agenda for Change National Pay framework to ensure that individuals are compensated equally for performing equivalent roles.

A significant factor affecting pay gaps is the disproportionate representation of men and white colleagues in senior positions and the overrepresentation of minoritised and female colleagues in lower-paid and part-time roles. Contractual legacy bonus factors for medics also influence pay gap comparisons. Although there is some unknown data regarding ethnicity and disability compared to gender data, it is possible to observe indications of these gaps based on existing known data. Statistically, the median is a more accurate measure as it is not skewed by very low or very high hourly pay rates.

Table 4. Pay Gap comparison 2021 – 24

Gender	2021/22	2022/23	2023/24	2024/25
Median	17.01%	16.46%	13.25%	12.36%

Ethnicity	2022/23	2023/24	2024/25
Median	3.59%	3.92%	

Disability	2022/23	2023/24	2024/25
Median	-4.95%	0.00%	

Upcoming 2024 pay gap reports for gender, disability and ethnicity are in development and will be available soon. In the meantime, we continue to build on our activity to address gaps.

Our Pay Gap Priorities 2024/25, taking an intersectional approach:

- **Inclusive Recruitment**: We introduced the guaranteed interview scheme for those who meet essential criteria and are ethnically diverse for roles at Agenda for Change pay bands 8b and above, along with a reflection form, and debiasing job descriptions. Continuation of exploring sharing interview questions in advance and expanded interview question bank to improve standards of hire around inequality and anti-racism competence and experience. This can also assist neurodivergent, carers, racialised or under-resourced people.
- **Learning and Development**: Launched talent and career conversations at mid-year appraisal. Created a 'Continuing Professional Development access' dashboard for detailed data analysis. Promoted the "Braver than Before" leadership programme in March 2025 for women and ethnically diverse colleagues in Agenda for Change Pay Bands 5 to 8a.
- **Culture and Engagement**: Published pay gap reports and collaborated with staff networks on related actions. Continued our Equality Network Steering Group to enhance cross-collaboration and joint efforts. Developed and introduced a new behaviours framework. Conducted a quality improvement project on reasonable adjustments to enhance staff experience when workplace adjustments are needed. Created an inclusion passport for staff, ensuring

smooth transitions between roles or managers

- **Women's Network**: celebrated a year of our Women's Network which has held events, webinars to support addressing gender inequality, support peer-to-peer support, and discuss work-life balance, flexible working, women's health, and promotion opportunities.

Analysis of Staff Costs

Analysis of staff costs between permanently employed and other staff. Permanently employed staff are those with a permanent (UK) employment contract with the Trust. Other staff include those who do not have a permanent (UK) employment contract and also includes bank, agency staff and other temporarily employed staff.

Employee benefits

	Permanent	Other	2024/25 Total	2023/24 Total
	£000	£000	£000	£000
Salaries and wages	209,700	-	**209,700**	**186,551**
Social security costs	22,419	-	**22,419**	**20,853**
Apprenticeship levy	1,043	-	**1,043**	**975**
Employer's contributions to NHS pensions	45,937	-	**45,937**	**35,717**
Pension cost - other (NEST)	35	-	**35**	**49**
Other employment benefits	45	-	**45**	**-**
External Bank Staff	-	23,876	**23,876**	**26,214**
Agency/contract staff	-	7,812	**7,812**	**8,268**
Total gross staff costs	**279,179**	**31,688**	**310,867**	**278,627**
Included within:				
Costs capitalised as part of assets	954	-	**954**	**711**
Total employee benefits excl. capitalised costs*	**278,225**	**31,688**	**309,913**	**277,916**

* Total employee benefits relates to employees and Executive Directors, but excludes Non-Executive Directors

Staff numbers *(the following information is subject to audit)*

Average number of employees (WTE basis)

	Permanent Number	Other Number	2024/25 Total Number	2023/24 Total Number
Medical and dental	179	26	**205**	**204**
Ambulance staff	-	-	**-**	**-**
Administration and estates	586	21	**607**	**678**
Healthcare assistants and other support staff	1,776	249	**2,025**	**1,728**
Nursing, midwifery and health visiting staff	1,183	132	**1,315**	**1,249**
Nursing, midwifery and health visiting learners	24	-	**24**	**20**
Scientific, therapeutic and technical staff	941	41	**982**	**993**
Healthcare science staff	15	-	**15**	**13**
Other	1	-	**1**	**1**
Total average numbers	**4,705**	**469**	**5,174**	**4,886**
Of which:				
Number of employees (WTE) engaged on capital projects	11	-	**11**	**9**

Payments and Trade Union Time

Table 1 - Total number of employees who were relevant Trade Union officials during 2023-24

Number of employees who were relevant Trade Union officials during 2024-25	Full-time equivalent employee number
21	17.5

Table 2 - Percentage of time spent on facility time

Percentage of time relevant Trade Union officials employed by the Trust during 2024/2025 spent working on facility time:

Percentage of time	Number of employees
0%	0
1-50%	20
51-99%	0
100%	1 (staff side chair)

Table 3 - Percentage of pay bill spent on facility time

The percentage of the total pay bill spent on paying employees who were relevant Trade

Union officials for facility time during 2024/2025:

First Column in Table 2 above	Figures
Total cost of facility time	<£50,000
Total pay bill	£309,913
The percentage of the total pay bill spent on facility time.	<1%

The Trust does not allow Trade Union representatives to attend meetings during work time which are defined by ACAS as: "time for which there is no specific right to be paid including meeting full-time officers, attending regional or branch meetings."

Sickness Absence Figures

The Trust's Sickness Absence Figures are below and are also published on the NHS

The adjusted full time equivalent days lost to sickness as defined by the Cabinet Office over the last 12 months was 44,450 days. This equated to 9.6 days of sickness per member of staff.

They are also published on the NHS Digital website at: https://digital.nhs.uk/data-and-information/publications/statistical/nhs-sickness-absence-rates

Following a review of the sickness absence management processes and a joint project involving Human Resources and operational colleagues, new working methods and an updated attendance policy have been introduced. One of the changes implemented is the early referral to occupational health for mental health-related absences to provide better support for individuals away from work due to well-being and mental health issues. Additional improvements include enhanced return-to-work check-in processes for staff after sickness and the removal of the requirement for self-certification for absences of up to 8 days.

These new working methods are designed to provide support for our staff during periods of illness and facilitate an early return to work where feasible. Specifically, we recognised the need to better support employees with mental health issues, understanding that early health interventions and support can significantly reduce sickness absence levels. A review of these changes and their impact on our sickness absence rates will be conducted in the spring of 2025, after the new working methods have been in operation for six months.

The following is subject to audit

Reporting of Compensation Schemes - Exit Packages 2024/25

	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages
	Number	Number	Number
Exit package cost band (including any special payment element)			
<£10,000	3	4	**7**
£10,001 - £25,000	2	1	**3**
£25,001 - £50,000			
£50,001 - £100,000			
£100,001 - £150,000			
£150,001 - £200,000			
>£200,000			
Total number of exit packages by type	**5**	**5**	**10**
Total resource cost (£)	55,000	35,000	**90,000**

Reporting of Compensation Schemes - Exit Packages 2023/24

	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages
	Number	Number	Number
Exit package cost band (including any special payment element)			
<£10,000	1	5	**6**
£10,001 - £25,000	1	-	**1**
£25,001 - 50,000	-	1	**1**
£50,001 - £100,000	1	-	**1**
£100,001 - £150,000	-	-	**-**
£150,001 - £200,000	-	-	**-**
Total number of exit packages by type	**3**	**6**	**9**
Total resource cost (£)	**112,000**	**50,000**	**162,000**

Exit packages: other (non-compulsory) departure payments

	2024/25		2023/24	
	Payments agreed	Total value of agreements	Payments agreed	Total value of agreements
	Number	£000	Number	£000

Voluntary redundancies including early retirement contractual costs	-	-	-	
Mutually agreed resignations (MARS) contractual costs	-	-	-	-
Early retirements in the efficiency of the service contractual costs	-	-	-	-
Contractual payments in lieu of notice	5	35	6	50
Exit payments following Employment Tribunals or court orders	-	-	-	-
Non-contractual payments requiring HMT approval	-	-	-	-
Total	**5**	**35**	**6**	**50**

Off Payroll Arrangements Disclosure

The NHS Foundation Trust reports arrangements whereby individuals are paid through their own companies (and so are responsible for their own tax and national insurance arrangements, not being classed as Trust employees). The costs of these off-payroll engagements are recorded in the expenditure of the Trust, within consultancy costs. The Trust made zero "off payroll" payments from 1 April 2024 to 31 March 2025. The Trust's disclosure is below:

Highly paid off-payroll worker engagements as of 31 March 2025 earning £245 per day or greater

Number of existing engagements as of 31 March 2025	**0**
Of which...	
Number that have existed for less than one year at the time of reporting.	0
Number that have existed for between one and two years at the time of reporting.	0
Number that have existed for between two and three years at the time of reporting.	0
Number that have existed for between three and four years at the time of reporting.	0
Number that have existed for four or more years at time of reporting.	0

Table 2: All highly paid off-payroll workers engaged at any point during the year ended 31 March 2025 earning £245 per day or greater.

Number of off-payroll workers engaged during the year ended 31 March 2025	**0**
Of which:	
Not subject to off-payroll legislation *	0
Subject to off-payroll legislation and determined as in-scope of IR35 *	0
Number of off-payroll workers engaged during the year ended 31 March 2025	**0**
Subject to off-payroll legislation and determined as out-of-scope of IR35	0

*	
Number of engagements reassessed for compliance or assurance purposes during the year	0
Of which: number of engagements that saw a change to IR35 status following review	0

* A worker that provides their services through their own limited company or another type of intermediary to the client will be subject to off-payroll legislation and the Trust must undertake an assessment to determine whether that worker is in scope of Intermediaries legislation (IR35) or out- of-scope for tax purposes.

Table 3: For any off-payroll engagements of board members, and/or senior officials with significant financial responsibility, between 1 April 2024 and 31 March 2025

Number of off-payroll engagements of board members, and/or senior officials with significant financial responsibility during the financial year.	**0**
Number of individuals that have been deemed 'board members and/or senior officials with significant financial responsibility' during the financial year. This figure must include both off-payroll and on-payroll engagements.	**0**

Exit packages: other (non-compulsory) departure payments

	2024/25		2023/24	
	Payments agreed Number	Total value of agreements £000	Payments agreed Number	Total value of agreements £000
Voluntary redundancies including early retirement contractual costs	-	-	-	
Mutually agreed resignations (MARS) contractual costs	-	-	-	-
Early retirements in the efficiency of the service contractual costs	-	-	-	-
Contractual payments in lieu of notice	5	35	6	50
Exit payments following Employment Tribunals or court orders	-	-	-	-
Non-contractual payments requiring HMT approval	-	-	-	-
Total	5	35	6	50

Off Payroll Arrangements Disclosure

The NHS Foundation Trust reports arrangements whereby individuals are paid through their own companies (and so are responsible for their own tax and national insurance arrangements, not being classed as Trust employees). The costs of these off-payroll engagements are recorded in the expenditure of the Trust, within consultancy costs. The Trust made zero "off payroll" payments from 1 April 2024 to 31 March 2025. The Trust's disclosure is below:

Highly paid off-payroll worker engagements as of 31 March 2025 earning £245 per day or greater

Number of existing engagements as of 31 March 2025	**0**
Of which...	
Number that have existed for less than one year at the time of reporting.	0
Number that have existed for between one and two years at time of reporting.	0
Number that have existed for between two and three years at the time of reporting.	0
Number that have existed for between three and four years at time of reporting.	0
Number that have existed for four or more years at the time of reporting.	0

Table 2: All highly paid off-payroll workers engaged at any point during the year ended 31 March 2025 earning £245 per day or greater.

Number of off-payroll workers engaged during the year ended 31 March 2025	**0**
Of which:	
Not subject to off-payroll legislation *	0
Subject to off-payroll legislation and determined as in-scope of IR35 *	0
Number of off-payroll workers engaged during the year ended 31 March 2025	**0**
Subject to off-payroll legislation and determined as out-of-scope of IR35 *	0
Number of engagements reassessed for compliance or assurance purposes during the year	0
Of which: number of engagements that saw a change to IR35 status following review	0

* A worker that provides their services through their own limited company or another type of intermediary to the client will be subject to off-payroll legislation and the Trust must undertake an assessment to determine whether that worker is in scope of Intermediaries legislation (IR35) or out- of-scope for tax purposes

Table 3: For any off-payroll engagements of board members, and/or senior officials with significant financial responsibility, between 1 April 2024 and 31 March 2025

Number of off-payroll engagements of board members, and/or senior officials with significant financial responsibility during the financial year.	**0**
Number of individuals that have been deemed 'board members and/or senior officials with significant financial responsibility' during the financial year. This figure must include both off-payroll and on-pay-roll engagements.	**0**

Modern Day Slavery Statement

This statement is made pursuant to Section 54 of the Modern Slavery Act 2015 and sets out the steps that Berkshire Healthcare NHS Foundation Trust has taken, and is continuing to take, to make sure that modern slavery or human trafficking is not taking place within our business or supply chain during the year ending 31 March 2024.

Modern slavery encompasses slavery, servitude, human trafficking and forced labour. Berkshire Healthcare has a zero-tolerance approach to any form of modern slavery. We are committed to acting ethically and with integrity and transparency in all business dealings and to putting effective systems and controls in place to safeguard against any form of modern slavery taking place within the Trust or our supply chain.

Our Policies on Slavery and Human Trafficking

Berkshire Healthcare is aware of our responsibilities towards patients, service users, employees and the local community and expects all suppliers to the Trust to adhere to the same ethical principles. We are committed to ensuring that there is no modern slavery or human trafficking in our supply chains or in any part of our business. Our internal policies replicate our commitment to acting ethically and with integrity in all our business relationships.

Standard NHS Contracts and the Trust's contract specifications contain a provision around Good Industry Practice to ensure each supplier's commitment to anti-slavery and human trafficking in their supply chains; and that they conduct their businesses in a manner that is consistent with Berkshire Healthcare's anti-slavery policy. In addition, an increasing number of suppliers are implementing the Labour Standards Assurance System (LSAS) as a condition of contract for tenders within high-risk sectors and product categories and indeed this has been referenced in the Government's Modern Slavery Strategy. Many aspects of the LSAS align to the seven reporting areas that the Government has outlined and should appear within any slavery and human trafficking statement.

We operate several internal policies which ensure that we are conducting business in an ethical and transparent manner. These include:

- **Recruitment** - We operate a robust recruitment policy, including conducting eligibility to work in the United Kingdom checks for all directly employed staff. Agencies on approved frameworks are audited to provide assurance that pre-employment clearance has been obtained for agency staff, to safeguard against human trafficking or individuals being forced to work against their will.
- **Fair and Equitable Employment Terms** - We have a range of controls to protect staff from poor treatment and/or exploitation, which complies with all respective laws and regulations. These include the provision of fair pay rates, fair terms and

conditions of employment, and fair access to training and development opportunities.

- **Safeguarding** - We adhere to the principles inherent within both our safeguarding children and adults' policies. These are compliant with the Berkshire multiagency agreements and provide clear guidance so that our employees are clear on how to raise safeguarding concerns about how colleagues or people receiving our services are being treated, or about practices within our business or supply chain.
- **Whistleblowing** - We operate a whistleblowing/raising concerns policy so that everyone in our employment knows that they can raise concerns about how colleagues or people receiving our services are being treated, or about practices within our business or supply chain, without fear of reprisals, and the various ways in which they can raise their concerns.
- **Standards of business conduct** - This code explains the manner in which we behave as an organisation and how we expect our employees and suppliers to act.

Our approach to procurement and our supply chain includes:

- Ensuring that our suppliers are carefully selected through our robust supplier selection criteria/processes.
- Requiring that the main contractor provides details of its sub-contractor(s) to enable the Trust to check their credentials.
- Ensuring invitations to tender documents contain a clause on human rights issues.
- Ensuring invitation to tender documents also contains clauses giving the Trust the right to terminate a contract for failure to comply with labour laws.
- Using the standard Supplier Selection Questionnaire (which includes a section on Modern Day Slavery), Trust staff must contact and work with the Procurement department when looking to work with new suppliers so appropriate checks can be undertaken.
- Supplier adherence to our values. We are zero tolerant to slavery and human trafficking and thereby expect all our direct and indirect suppliers/contractors to follow suit.
- Where it is verified that a subcontractor has breached the child labour laws or human trafficking, then this subcontractor will be excluded in accordance with Regulation 57 of the Public Contracts Regulations 2015. The Trust will require that the main contractor substitute a new subcontractor.

Training

Advice and training about modern slavery and human trafficking is available to staff through our mandatory safeguarding children and adults training programmes, our safeguarding policies and procedures, and our safeguarding leads. It is also discussed at our corporate induction training which is mandatory for all our new starters. We are looking at ways to continuously increase awareness within our organisation, and to ensure a high level of understanding of the risks involved with modern slavery and human trafficking in our supply chains and in our business.

Our Performance Indicators

We will know the effectiveness of the steps that we are taking to ensure that slavery and/or human trafficking is not taking place within our business or supply chain if there are no reports received from our staff, the public, or law enforcement agencies to indicate that modern slavery practices have been identified.

Anti-Crime Activity

The Trust operates a robust arrangement for minimising the risk of fraud and meets the requirements of the Secretary of State that each health body nominates an officer to act as its Local Counter Fraud Specialist. As well as handling suspected cases of fraud, the service provides awareness and educational support to help embed an 'anti-fraud' culture throughout the organisation. There is a clear policy on counter fraud together with other provisions to support staff in raising concerns about possible fraudulent activity.

Health and Safety

The Trust's arrangements for the health and safety of staff, patients, visitors and others are set out in a clear organisational policy that emphasises the organisation's commitment to providing a safe place to work and a healthy environment for all.

A comprehensive suite of policies and procedures are in place to ensure that risks to the health and safety of all are minimised and these policies and procedures are reviewed regularly to ensure the effectiveness of the Trust's health and safety management system.

The Trust produces an annual Health and Safety report, which reviews the Trust's performance on a range of categories, comparing results to the previous year and national figures. Key points of note include:

- The Trust received no Enforcement Notices from the Health and Safety Executive or the Local Authorities in 2024/2025.
- There were five incidents reported under the RIDDOR regulations in the year 2024/2025, (with no false reports) showing a decrease of six incidents compared to 2023.
- 690 physical assaults against staff were reported during the period, which is a decrease of 119 (13%) compared to 2023/24.
- 1,026 non-physical assaults against staff were reported during the period, an increase of 101 (10%) on the previous year.
- During 2024/2025, following on from an incident at Prospect Park Hospital the Royal Berkshire Fire and Rescue Service undertook one fire safety visits to

ensure the Trust was compliant with the Regulatory Reform (Fire Safety) Order 2005, and to complete a post incident inspection.

- There were four cases of arson reported for 2024/2025, and eleven cases of a risk of fire being identified. Six out of eleven of the incidents were community based with the remainder being on Trust property. Three of the eleven incidents occurred at Prospect Park Hospital, which is the same number of Prospect Park Hospital incidents for this category as the previous year.
- Compliancy in statutory training: Fire Awareness – The number of staff trained throughout 2023 has averaged 93.85%. This is a 0.46% increase from last year (2023/24 average = 92.71%). This falls 1.15% short of the Trust's fire training target of 95% compliance.
- Compliancy in statutory training: Health & Safety - The number of staff trained throughout 2024/25 has averaged 97.5 % (1.3 % increase). This is above the Trust's target of 90% compliance.
- The overall sickness rate for 2024/2025 was 4.28%, an increase from 4.15% in 2023/2024. The most common reason for absence remains anxiety/stress/depression, accounting for 27.2% of all sickness in the 12-month period. Covid related sickness accounted for 2.55% of all sickness absence in 2024, a decrease from 4.90% in 2023/2024. Absences attributed to musculoskeletal/back problems accounted for 8.5% - an increase from 6.8%.
- The number of full-time equivalent days lost to sickness in 2024/2025 has increased by 8.77% when compared to 2023/2024. The overall sickness rate for Covid related sickness for the year was 0.14%. If Covid related sickness is excluded from the figures, the overall sickness rate for 2024/2025 was 4.17%, an increase from 3.95% in 2023/2024.

Julian Emms
Chief Executive
18 June 2025

COUNCIL OF GOVERNORS

The Council of Governors plays a crucial role in the governance of the Trust providing a forum through which the Trust Board is accountable to the local community. The Council is responsible for a number of key responsibilities including:

- Representing the interests of the Trust's members and stakeholder organisations in the governance of the Trust
- Appointing or removing the Chair and other Non-Executive Directors
- Approving the appointment (by the Non-Executive Directors) of the Chief Executive
- Deciding the remuneration, allowances and other terms and conditions of office of the Chair and other Non-Executive Directors
- Holding the Non-Executive Directors to account for the performance of the Board
- Considering the annual accounts, plus any reports of the external auditors on them and the annual report
- Appointing the External Auditors
- Developing and approving the Trust's membership strategy
- Providing views to the Trust Board on the Trust's forward planning
- Undertaking functions requested from time to time by the Trust Board
- Attending events in order to engage with members and the public
- Attendance at the Annual Members Meeting.

Membership of Council

During 2024-25 there were 32 positions on the Council of Governors:

- 23 elected from the public and staff constituencies
- 9 appointed from local authorities, universities and voluntary organisations

The elected governors were drawn from the following constituencies:

- Public constituency – total of 19
- Staff constituency – total of 4

Public and Staff Governors are elected to serve for three years. Individuals can stand for re-election at the end of their term for a maximum of three terms (nine years).

Appointed Governors are appointed by their individual organisations in accordance with the respective organisation's appointment to external bodies processes.

The annual election of Lead and Deputy Lead Governor also took place in September 2024 with Governors appointing Brian Wilson as Lead Governor and appointing Jon Wellum as Deputy Lead Governor.

The following table shows the attendance record of Governors at Council meetings during the year.

The meetings were held virtually.

Name	Constituency	Meetings attended/possible
Graham Bridgman	Public – West Berkshire	04/04
Ros Crowder	Public – West Berkshire	04/04
Ian Germer	Public – West Berkshire	04/04
Madeline Diver	Public – Bracknell	04/04
Rosemary Stent	Public – Bracknell (until June 2024)	00/01
Hilary Doyle	Public – Bracknell (from July 2024)	01/03
Brian Wilson	Public – Bracknell *(Lead Governor)*	04/04
Sarah Croxford	Public – Windsor, Ascot & Maidenhead	02/04
Tom O'Kane	Public – Windsor, Ascot & Maidenhead	00/04
Natasha Afful	Public – Slough (until June 2024)	00/01
Aryan Sharma	Public – Slough (from July 2024)	01/03
Steven Gillingwater	Public – Slough	00/04
Nigel Oliver	Public – Slough	00/04
Debra Allcock-Tyler	Public – Wokingham	02/04
Baldev Sian	Public – Wokingham	04/04
John Jarvis	Public – Wokingham (until June 2024)	00/01
Jon Wellum	Public – Reading *(Deputy Lead Governor)*	03/04
George Mathew	Public – Reading (from July 2024)	03/03
Tom Lake	Public – Reading (until June 2024)	01/01
James Cuggy	Public – Reading	04/04
Amran Hussain	Rest of England (until June 2024)	00/01
John Featherstone	Rest of England (from June 2024)	03/03
Tina Donne	Staff – Clinical (until July 2024)	01/01
Marcella Browne	Staff – Clinical (from 08.12.24)	01/01
Anne Jumba	Staff – Clinical	02/04
Guy Dakin	Staff – Non-Clinical	04/04
Alun Griffiths	Staff – Non-Clinical	02/04
Michael Karim	LA – Bracknell	00/04
Deborah Edwards	LA – Reading (until 7 June 2024)	00/01
Jacopo Lanzoni	LA – Reading (from 14 June 2024)	02/04
Anna Wright	LA – Slough	04/04
George Shaw	LA – Windsor and Maidenhead	02/04
Jordan Mongomery	LA – Wokingham	00/04
Janine Lewis	LA – West Berkshire (until July 2024)	00/01
Patrick Clerk	LA – West Berkshire (from August 2024)	01/03
Babs Evetts	Reading University	01/04

Name	Constituency	Meetings attended/possible
Elaine Walsh	British Red Cross (until August 2024)	00/01
Sarah Collin	Family Action Org Uk (from 6 December 2024)	00/01
Fiona Price	Age UK Berkshire (from September 2024)	02/03

During 2024-25, there were four formal meetings of the Council which were conducted virtually. Publicity was given through the Trust's website. From September 2020, the recording of the full Council meetings has been published on the Trust's website along with the agenda and meeting papers.

In September 2025, the Trust held a virtual Annual Members Meeting where the Trust's Annual Report and Accounts were presented.

The Council has also put in place a structure of committees and steering groups to help fulfil its duties and each Committee reports back to the full Council at each Council meeting. The Committees/Working Groups are:

- Membership and Engagement Group
- Living Life to the Full Group
- Appointments and Remuneration Committee
- Quality Assurance Group

Working Relations between the Council and the Trust Board

Strong working relationships continue between the Council and Trust Board with regular engagement, involving Executive and Non-Executive Director attendance at Council meetings, joint informal meetings between Council and the Board, including two meetings a year specifically with Non-Executive Directors. The Joint Trust Board and Council of Governors meeting held in November each year focusses on the Trust's forward plan and provides an opportunity for governors to input into the forward plan and to feedback any views from their local communities.

The Chief Executive attends all meetings of the full Council and other Executive Directors attend as and when required. The meetings held with Non-Executive Directors have been useful in supporting Governors to discharge their duty to hold the Non-Executive Directors to account for the performance of the Board and for seeking assurance on service quality and financial sustainability. For new Governors joining the Trust during the year induction training was provided involving the Trust Chair and Company Secretary.

Governors can submit written questions before the informal Joint meetings with the Trust Board and Council of Governors. The Chief Executive and other Executive

Directors provide written answers to the questions at the meetings.

At each of the informal joint meetings, there is a private session whereby small groups of Governors meet with Non-Executive Directors to have informal discussions. This provides an opportunity for Governors to share with Non-Executive Directors the views of members and the public about the Trust. The format of this session is café style whereby individual Non-Executive Directors rotate between the Governor groups every 15-20 minutes.

The Chair holds regular informal virtual "Coffee Morning" sessions which are open to all governors. This provides an opportunity for governors to raise issues with the Chair and to discuss relevant issues in between formal meetings.

Council of Governors and Trust Board Dispute Process

In the event of any dispute between the Council of Governors and the Trust Board, the Chair on the advice of the Company Secretary, and such other advice as the Chair may see fit to obtain, shall seek to resolve the dispute. If the Chair is unable to resolve the dispute, they shall appoint a special committee comprising equal numbers of Directors and Governors to consider the circumstances and to make recommendations to the Council of Governors and the Trust Board with a view to resolving the dispute. If the recommendations (if any) of the special committee are unsuccessful in resolving the dispute, the Chair may refer the dispute back to the Trust Board who shall make the final decision.

The Trust's Constitution sets out the process for the Council of Governors to remove the Trust's Chair and Non-Executive Directors in the event that all other means of engaging with the Trust Board have been exhausted.

Farewell and welcome

Sadly, John Jarvis, Public Governor, Wokingham passed away in June 2024. John was a hardworking and well-respected Governor and had made a significant contribution to the work of the Council of Governors.

In 2024-25 a number of Governors left, and we welcomed others. Whilst it is always disappointing to lose experienced Governors, the Council benefits immensely from the injection of different perspectives and ideas that new Governors bring.

Our thanks go to our departing Governors: Rosie Stewart, Public Governor, Bracknell, Natasha Afful, Public Governor, Slough, Tom Lake, Public Governor, Reading, Amran Hussain, Public Governor, Rest of England, Deborah Edwards, Appointed Governor, Reading Borough Council, Janine Lewis, Appointed Governor, West Berkshire Council. Elaine Walsh, Red Cross and Tina Donne, Staff Governor, Clinical

We warmly welcomed: Hilary Doyle, Public Governor, Bracknell, John Featherstone, Public Governor, Rest of England, Aryan Sharma, Public Governor, Slough, Jacopo Lanzoni, Appointed Governor, Reading Borough Council, Patrick Clerk, Appointed Governor, West Berkshire Council, Fiona Price, Appointed Governor, Age Uk Berkshire, Sarah Collin, Appointed Governor, Family Action Org Uk and Marcella Browne, Staff Governor, Clinical.

Governor Expenses

The role of Governor is unpaid; however, they are entitled to claim reimbursement of expenses, such as travel and subsistence costs. During 2024-25 3 governors claimed expenses with an aggregate value of £72.00.

Elections

Public and Staff Governors are elected by the membership of the relevant constituency, and they serve for a period of three years. They can be re-elected and can serve for a maximum of nine consecutive years. The following table provides information on the results of Governor Elections held during the year:

Date of Election	Constituency	Election turnout %
July 2024	**Rest of England**	**Uncontested**
July 2024	**Slough**	**Uncontested**
July 2023	**Bracknell**	**7.3%**
July 2023	**West Berkshire**	**8.3%**
June 2023	**Staff – Non-Clinical**	**23.5%**
June 2023	**Staff – Clinical**	**6.1%**

All elections were completed and supervised by Civica Election Services and were conducted in accordance with the Trust's Constitution.

Partnership Governors are appointed by the relevant organisation.

Register of interests

A register of interests is maintained for Governors. It is available by contacting the Trust's Company Secretary.

MEMBERSHIP

Berkshire Healthcare became an NHS Foundation Trust in 2007. Foundation status was only awarded to NHS Trusts who consistently demonstrated the highest standards of leadership and patient care.

As an NHS Foundation Trust, we are required to maintain a membership base which is representative of the communities we serve. Our members and governors help shape our plans and make sure that the services we provide reflect what is needed locally.

Anyone over 12 can become a member, although we do not actively recruit anyone under 16. The Marketing and Communications Team is currently responsible for recruiting and communicating with our membership.

As of March 2025, our total membership is 12,660 (made up from both our staff and members of the public).

Engagement with members

Our focus has been on maintaining membership numbers and incorporating more social media to promote membership within demographics where we are lacking.

Over the last year, engagement with our members has included an invitation to attend our Annual General Meeting, quarterly e-newsletters updating members on health topics and news from the Trust, and involvement in Reading Pride, the latter being a key member recruitment event. We also sent an email to public members to take part in focus groups for our website redevelopment project.

Our current membership numbers in each local authority area are shown below.

Current public membership by area on 4 April 2025

Constituency Breakdown	Public	% of Membership	Base	% of Area
Bracknell	885	12.19	129,275	13.28
Reading	1,707	23.52	177,428	18.22
Slough	670	9.23	161,459	16.58
West Berkshire	724	9.97	163,575	16.80
Windsor and Maidenhead	623	8.58	156,557	16.08
Wokingham	954	13.14	185,444	19.05
Rest of England	1,400	19.29	0	0.00
Out of Trust Area	296	4.08	0	0.00
Total	**7,259**	**100.00**	**973,738**	**100.00**

Most of our public members live in Berkshire, however a few live outside of Berkshire due to their interest in our organisation. These members are part of our 'Rest of England' constituency.

They may be:

- Family members or carers who look after or are responsible for someone who uses our services.
- Someone who has moved away from the county and wishes to maintain links with us.

The 'Out of Trust Area' category refers to members whose postcodes are not recognised. Our database provider, CIVICA Group, uses the Royal Mail Postcode Address File (PAF) for UK addresses.

The table below shows the size of our current membership and the movement in numbers of members compared to 2023-2024.

Public constituency	**2023/2024**	**2024/2025**	**Percentage change**
At year start (1 April)	7,648	7,267	**-5%**
New members	58	56	**-3%**
Members leaving	439	64	**+85%**
At year end (31 March)	7,267	7,259	**-0.1%**
Staff constituency	**2023/2024**	**2024/2025**	**Percentage change**
At year start (1 April)	5,302	5,388	**+1.6%**
New members	785	522	**-33%**
Members leaving	699	509	**-27%**
At year end (31 March)	5,388	5401	**+0.2%**

Public membership analysis

The table below shows our public membership by age, ethnicity, socio-economic background, and gender. Membership population figures have been provided by CIVICA Group, our database provider, and are taken from the Census.

The index column displays how on target we are with representing the communities we serve. Generally, a score under 100 means there is an under representation and a score above 100 indicates an over representation.

*However, not all members have provided full details to allow for accurate classification, in areas such as ethnicity, many members have stated 'other' as their ethnicity if they do not fall into the White, Black, Asian, or mixed categories given.

Red indicates under representation in the particular membership category.

Green indicates over representation in the particular membership category.

Age	Public	% of Membership	Base	% of Area	Index
0-16	4	0.06	205,014	21.05	0
17-21	39	0.54	56,805	5.83	9
22+	5,965	82.17	711,921	73.11	112
Not stated	1,251	17.23	0	0.00	0
Age	5,965	82.17	711,921	73.11	
22-29	378	5.21	92,297	9.48	55
30-39	1,515	20.87	140,127	14.39	145
40-49	837	11.53	142,027	14.59	79
50-59	929	12.80	128,080	13.15	97
60-74	**1,359**	**18.72**	**133,111**	**13.67**	**137**
75+	947	13.05	76,279	7.83	167
Gender	7,259	100.00	973,738	100.00	
Unspecified	742	10.22	0	0.00	0
Male	2,344	32.29	482,219	49.52	65
Female	4,159	57.29	491,519	50.48	114
Other	12	0.17	0	0.00	**0**
Prefer not to say	**2**	**0.03**	**0**	**0.00**	0
Ethnicity	7,251	99.89	926,632	100.00	
Asian	614	8.46	162,748	17.56	48
Black	248	3.42	36,150	3.90	88
Mixed	149	2.05	33,663	3.63	57
Other	**1,136**	**15.65**	**0**	**0.00**	**0**
White	5,104	70.31	694,071	74.90	94
Acorn **Socio-Economic Category**	7,259	100.00	952,179	100.00	
Affluent Achievers [1]	1,946	26.81	51,963	5.46	491
Rising Prosperity [2]	749	10.32	262,402	27.56	37

Age	Public	% of Membership	Base	% of Area	Index
Comfortable Communities [3]	1,827	**25.17**	**305,268**	**32.06**	**79**
Financially Stretched [4]	1,596	21.99	162,053	17.02	129
Urban Adversity [5]	759	10.46	138,707	14.57	72
Not Private Households [6]	**103**	1.42	31,786	3.34	43
Not available [NA]	279	**3.84**	**0**	**0.00**	0
ONS/Monitor Classifications	6,904	95.11	368,315	100.00	
AB	2,032	**27.99**	**115,832**	**31.45**	**89**
C1	2,085	28.72	113,519	30.82	93
C2	1,333	18.36	67,644	18.37	100
DE	**1,454**	20.03	71,320	19.36	103
Wellbeing Acorn Group	7,259	**100.00**	**973,738**	**100.00**	
Health Challenges [1]	553	7.62	62,730	6.44	118
At Risk [2]	1,358	18.71	163,568	16.80	111
Caution [3]	2,146	29.56	276,522	28.40	**104**
Healthy [4]	2,731	**37.62**	**462,145**	**47.46**	79
Not Private Households [5]	69	0.95	8,773	0.90	106
Not available [NA]	402	5.54	0	0.00	0
Total membership	7,259	100.00	973,740	100.00	

Plans for 2024-25

We are comfortably over the 10,000-member threshold that we hold as a target within our membership strategy. Therefore, we will continue our focus on recruiting new members from demographics which are underrepresented in our current membership, for example young people, men, and those living outside of Reading.

To do this, we will post regularly on our social media channels and issue our dedicated members' e-newsletter quarterly to maintain levels of engagement and communicate key information. We will also attend Reading Pride again this year to encourage more members to sign up. Reading Pride always has a diverse attendance which allows us to tap into Berkshire's demographics where we have smaller membership numbers.

We have recently refreshed our governor and membership leaflets, ensuring our materials are inclusive and representative, as well as being digital-friendly, and both of these signpost to our online membership application form.

In addition, to bolster our membership recruitment efforts, we are planning a new 'Health Talk' series, hosted by the Trust virtually and available exclusively to our members. Specialist clinicians will cover topics that are particularly relevant to those people who are underrepresented in our membership. We will pilot at least two talks this financial year and then assess whether or not we should roll out additional talks throughout the following year.

Contacting our Governors or Directors

Details of our Governors, as well as our Executive Directors and Non-Executive Board members, can be found in the 'About us' section of our website: www.berkshirehealthcare.nhs.uk

Contacting our Governors or Directors

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Governors and Board Members can be contacted via the Company Secretary at: trustboard@berkshire.nhs.uk

PUBLIC DISCLOSURES

Accounts note

NHS England has directed that the financial statements of NHS Foundation Trusts should meet the accounting requirements of the NHS Trust Financial Reporting Manual which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the 2024-25 NHS Foundation Trust Annual Reporting Manual issued by NHS England. The accounting policies contained in that manual follow International Financial Reporting Standards (IFRS) and HM Treasury's Government Financial Reporting Manual to the extent that they are meaningful and appropriate to NHS foundation trusts. The accounting policies have been applied consistently in dealing with items considered material in

relation to the accounts.

Cost allocation

Berkshire Healthcare NHS Foundation Trust has complied with the cost allocation and charging requirements set out in HM Treasury and Office of Public Sector Information guidance.

Berkshire Healthcare NHS Foundation Trust

Annual accounts for the year ended 31 March 2025

Foreword to the accounts

Berkshire Healthcare NHS Foundation Trust

These accounts, for the year ended 31 March 2025, have been prepared by Berkshire Healthcare NHS Foundation Trust in accordance with paragraphs 24 & 25 of Schedule 7 within the National Health Service Act 2006

Signed …….

Name **Julian Emms**
Job title **Chief Executive Officer**
Date **18th June 2025**

Statement of accounting officer's responsibilities

The NHS Act 2006 states that the chief executive is the accounting officer of the NHS foundation trust. The relevant responsibilities of the accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the *NHS Foundation Trust Accounting Officer Memorandum* issued by NHS England

NHS England, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given Accounts Directions which require Berkshire Healthcare NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Berkshire Healthcare NHS Foundation Trust and of its income and expenditure, other items of comprehensive income and cash flows for the financial year.

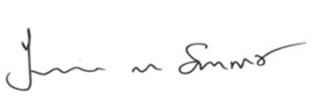
In preparing the accounts and overseeing the use of public funds, the Accounting Officer is required to comply with the requirements of the Department of Health and Social Care Group Accounting Manual and in particular to:

- observe the Accounts Direction issued by NHS England, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis make judgements and estimates on a reasonable basis;
- state whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual (and the Department of Health and Social Care Group Accounting Manual) have been followed, and disclose and explain any material departures in the financial statements;
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance;
- confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS foundation trust's performance, business model and strategy; and
- prepare the financial statements on a going concern basis and disclose any material uncertainties over going concern.

The accounting officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS foundation trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the NHS foundation trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

As far as I am aware, there is no relevant audit information of which the foundation trust's auditors are unaware, and I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the entity's auditors are aware of that information.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in the *NHS Foundation Trust Accounting Officer Memorandum.*



Julian Emms, Chief Executive Officer
Date: 18th June 2025

Scope of Responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS Foundation Trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS Foundation Trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the NHS Foundation Trust Accounting Officer Memorandum.

The Purpose of the System of Internal Control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Berkshire Healthcare NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively, and economically. The system of internal control has been in place in Berkshire Healthcare NHS Foundation Trust for the year ended 31 March 2024 and up to the date of approval of the annual report and accounts.

Capacity to Handle Risk

The existing comprehensive Risk Management Strategy has been reviewed and approved by the Executive and the Board. It has been disseminated through the Trust. The Chief Financial Officer and Director of Nursing and Therapies provide overall leadership for integrated governance at Board level. The Medical Director is the Caldecott Guardian. The Deputy Chief Executive is the Senior Information Risk Owner.

The Chief Executive chairs the monthly Business, Finance & Strategy Executive Committee and the Executive Quality and Performance Committee. Both these committees include the Chief Financial Officer who is Chair of the Non-Clinical Risk Management Committee, and the Director of Nursing and Therapies who is Chair of the Safety, Experience & Clinical Effectiveness Group together with the rest of the Executive Directors and senior management representatives. The Board Assurance Framework (BAF) and Corporate Risk Register (CRR) is reviewed at the Business, Finance & Strategy Executive Committee bi-monthly, with clinical and operational risks also being reviewed in the Executive Quality and Performance Committee.

The Executive routinely oversees the effectiveness of all other Committees within the governance structure through the receipt of minutes and reports via each of the two Formal Executive Committees (Business, Finance and Strategy, Quality and Performance). The Trust operates in a complex environment with many services dispersed around the county. Each service has its own Risk Register regularly reviewed through line management arrangements. Performance, Patient Safety & Quality Groups (PPSQs) monitor the divisional risk registers and Operational Leadership Team, chaired by the Chief Operation Officer, reviews new risks or changes to rating. Directors leading corporate services have the responsibility for ensuring similar Risk Registers are in place for support services. Escalation of appropriate local service level risks to the CRR is undertaken if necessary following review by the relevant Executive Director.

Risk Management training is part of the corporate induction for all new staff. In addition, all existing staff are required to undertake all mandatory training in the year, to comply with the CQC's Essential Standards of Care; this training includes Fire Awareness, Lifting and Handling and Health & Safety. Clinical staff undertake additional clinical mandatory training, which includes an update on clinical risk management.

All Policies and Procedures are published on the Trust intranet and are available to all staff. Relevant Policies include as example, Serious Untoward Incidents, Health and Safety, Infection Control, Information Governance and Freedom to Speak Up: Raising Concerns (Whistle Blowing) policy.

The Trust Audit Committee as the senior Board Sub Committee responsible for corporate governance assurance continues to review risk reporting and risk management and has done so during 2023/24. The Audit Committee continues to seek best practice guidance and received further assurance from internal audit review of the Trust's Risks Management procedures.

The Risk and Control Framework

The Trust's Risk Management Strategy seeks to minimise risk to the Trust's stakeholders through a comprehensive system of internal controls, risk management and assurance processes, whilst maximising the potential for flexibility, innovation, and best practice in the delivery of its strategic objectives. It seeks to deliver high quality, safe services for service users and secure the health, safety, and welfare at work of all employees and others on the Trust premises.

The Trust uses a standardised risk assessment tool that enables risks to be graded and scored. The tool requires the individual reporting the risk to determine the risk level at the time of detection and to forecast the risk level that will be achieved following implementation of a risk mitigation plan. The risks to delivery of corporate objectives on the BAF and relevant risks on CRR have been reviewed in detail by the Board, Audit Committee and Finance, Performance, and Investment Board sub-committees during the year.

The Trust recognises that it is not possible or always desirable to eliminate all risks and that systems should not stifle innovation. When all reasonable control mechanisms have been put in place some residual risk will inevitably remain in many Trust processes and this level of risk must be accepted. Risk acceptance within the Trust is systematic, explicit, and transparent. Where residual risk remains, the risk will remain on the BAF, CRR or local risk register. This ensures that it is reviewed through the control systems rather than having been removed from the register and therefore out of sight.

The Safety, Experience & Clinical Effectiveness Group chaired by the Executive Director of Nursing & Therapies provides the oversight of trust-wide strategic quality and safety related meetings such as Safeguarding Adults/Children, Drug and Therapeutic committees. The Group reports to the Quality and Performance Executive Committee chaired by the CEO and is the lead Executive committee for assuring the quality and safety of services through to the Board Quality Assurance Committee and the Audit Committee, with the Audit Committee providing overall governance assurance and scrutiny.

The Non-Clinical Risk Committee chaired by the Chief Financial Officer group provides the oversight of risk relating to Information Governance, Health & Safety, Fire and Medical Devices amongst others. The Group reports to the Business, Finance & Strategy Executive Committee chaired by the CEO and reports through to Finance, Investment & Performance Committee, and the Audit Committee, with the Audit Committee providing overall governance assurance and scrutiny.

Routine assurance of compliance with CQC registration requirements and fundamental standards of care is undertaken by the Divisional Patient Safety and Quality Groups. Clinical services review their compliance with CQC standards as part of ongoing monitoring reported into Patient Safety and Quality Groups and through supportive internal inspections coordinated by the Trust Patient Safety Team. Where recommendations for improvement arise from the internal inspections, service level action plans are developed and followed up to ensure continuous improvement. Quality Improvement methodology is used to support ongoing improvements at both Trust and local level.

The Trust was subject to core services and well led inspections by the CQC in November and December 2019, which in March 2020 resulted in an "Outstanding" overall rating for the organisation and its services. The Trust achieved "Good" ratings across inspection domains for Safety, Effectiveness and Caring. The Trust was rated 'Outstanding' in the Responsive and Well-led[1] domains, confirming the leadership and governance arrangements within the Trust are of a high quality and robust. This was the second year running the Trust has been rated "Outstanding" in the well led domain.

Performance information related to quality and patient safety metrics are reviewed and cross referenced with other intelligence available to the governance team prior to inclusion in Trust performance and quality reporting. The metrics are regularly reviewed with the governance and performance team. Governance of data quality in relation to quality metrics is overseen by the Audit Committee through review of the Trust's Information Assurance Framework.

[1] NHS England's Well-led framework is published at https://www.england.nhs.uk/well-led-framework/

The Trust completes the Data Security and Protection Toolkit each year and, in this year, has achieved a "standards exceeded" green rating, supported by over 95% of staff completing annual information governance training.

Ultimate responsibility for Information Security rests with the Chief Executive of the Trust. This responsibility is delegated to the Deputy Chief Executive as Senior Information Risk Owner (SIRO). Responsibility is further delegated to all staff developing, introducing, managing, and using information and information technology systems through the medium of the Information Governance policy.

The Trust IT Compliance & Audit Manager is responsible for the co-ordination of all aspects of computer security and for ensuring that the Trust Information Governance Policy and practice is consistent with those defined and published by the NHS.

Service managers are responsible for the protection of all information and information technology assets within their department.

Line Managers are responsible for ensuring that their permanent and temporary staff and contractors are aware of the following:

- The information security policies applicable in their work areas.
- Their personal responsibilities for information security.
- How to access advice on information security matters.

All staff must comply with Information Governance security procedures including the maintenance of data confidentiality and data integrity. Failure to do so may result in disciplinary action. The Information Security Policy is maintained, reviewed, and updated by the Trust. This review takes place annually.

Contracts with external contractors that allow access to the Trust's information systems must always be in operation before access is allowed. These contracts will ensure that the staff or sub-contractors of the external organisation will comply with all appropriate security and confidentiality policies.

The Trust is ever conscious of cyber security risk and is performing strongly against NHS England's cyber security standards and retained cyber essentials plus re-accreditation in 2023/24. The Executive Committee, Audit Committee and Board receive regular updates on risks and mitigations in this area.

The BAF contains the following key current and future business and operating risks:

Key Risk	**How they are managed / mitigated**
Workforce Due to national workforce shortage and increasing scarce supply there is a risk of failure to recruit and retain staff which could impact on our ability to meet our commitment to providing safe, compassionate, high-quality care and a good patient experience for our service users.	• Deliver People and Equality, Diversity & Inclusion (EDI) Strategies Using a QI approach and working with Ops colleagues to address turnover and retention. • Continued focus on key element of our People Plan to include: o Growing & Retaining our People: Attraction & Retention o Training & Clinical Education o Engagement, Wellbeing & Rewards o Just Culture o Talent & Leadership o Remote working & digital transformation • Strategic People Group and Diversity Steering Group provides oversight of this work monthly.

Demand and Capacity There is a risk that the Trust will fail to transform services and that some services, even after making internal efficiencies and productivity gains will be unable to keep up with increased demand leading to increased waiting times thus increasing the risk of harm to patients	• Systems and process are in place to identify potential areas of risk and escalate specific needs to Executive Directors for resolution. • Divisions & Services monitor service performance and coordinate allocation of resources across boundaries to cover shortfalls • Deep dives, Quality Improvement Programme Reviews and Business Cases to address pressures • Triaging system in place for patients on waiting lists
Patient Voice There is a risk that that the Trust will fail to "hear the patient voice" and take account of patient experience when shaping, adapting, and designing services leading to services which do not meet the needs of all groups of patients and their families leading to inequality of access and poorer health outcomes.	• Implementation of patient experience tool and use of the feedback provided • Lived experience workforce • Increasing use of service user coproduction in quality improvement • Use of QI to reduce priority health inequalities • Waiting and flow programme to reduce waits and waiting times, improve patient experience and reduce harm from waiting
System Working There is a risk that due to political, operational, workforce and funding pressures across health and care the Integrated Care Systems fail to deliver on their core aims of improving population health outcomes, reducing health inequalities, increasing system efficiency and contributing to wider social and economic development.	• Strong Trust representation on committees across both BOB and Frimley. Deputy CEO on Frimley ICS Board, MD membership of BOB ICS Board • Executive and senior leadership leading/engaged in key system transformation and provider collaborative programmes. • Membership of BOB and Frimley Integrated Care Partnership (NED representation) • Chair membership of Berkshire West ICP leaders group
Health Inequalities Given the complexity of the determinants of health including non-health related factors, there are risks around delivering an ambitious programme of work aimed at reducing health inequalities given the long lead in time to see any improvements and outcomes impacted by factors outside of health and social care	• Berkshire wide health inequalities steering group • Anti-Racism Strategy with health inequalities focus and specific anti-racism in healthcare community engagement forum developed • Patient and Carer Race Equality Framework implementation plan development • Trust Reducing Health Inequalities Oversight group chaired by Deputy CEO. • Programme of reducing MHA detentions

Finance Failure to achieve system defined target efficiency and cost base benchmarks lead to an impact on funding flows to the Trust, and underlying cost base exceeding funding. Risk is described in the context of system funding allocations being allocated and controlled at ICS level, flowing to providers on a risk share and/or relative efficiency basis.	• The Trust has delivered better than plan in 2023/24. • Effective financial planning process, management of expenditure within agreed within system funding allocations. • Regular reporting and discussion at Trust Business Group/Business, Finance & Strategy Executive Committee, Finance, Investment and Performance Committee and Board oversight
Digital Risk There is a risk that capital funding constraints will reduce the Trust's ability to invest in digital technology and innovation which is needed in order to maximise capacity (both clinical and non-clinical) and reduce the risk of malware attack which could compromise systems leading to unavailability of clinical systems, loss of data, ransom demands for data and mass disruption.	• Latest Anti-malware software is installed on all computers and servers and networks protected by firewalls. • Range of tools deployed, incoming email scanning, website filtering, critical security patch deployment. • Information security policy in place which details acceptable use of IT. • Network access for all windows end-point devices, digital patient records, digital staff records apps and devices protected via multi-factor authentication • Annual Cyber Security report to Audit Committee • Periodic external penetration tests
Sustainability There is a risk that the Trust's will not be able to deliver its Green Plan due to a lack of resources including access to capital funding and a focus on short rather than long term initiatives.	• Published Green Plan Net Zero 'n Green 2022-2025 and associated Green Action Plan • Sustainability Lead in place • Sustainability policies • Produce heat decarbonisation plans for core BHFT sites • Develop Green travel plan • Annual update on progress on Green Plan and Sustainability provided to Board

The above BAF risks can also be deemed to be "principal" risks to maintaining the NHS Foundation Trust licence condition 4 (FT governance). Further risk control and mitigation assurance is described throughout this Annual Governance Statement in terms of the governance structures and processes (Board and Executive and local level) that the Trust operates to minimise risk against this operating licence condition.

Risk management is embedded in the organisation through, for example, a locality represented Health & Safety Committee reporting into the Executive Non-Clinical Risk Committee, chaired by the Chief Financial Officer. Local risk registers are directly managed at service level with local risks and mitigation overseen by and reported up through the Operational and Senior Leadership Teams for escalation through to an Executive Director and the BAF / Corporate Risk Register. Local risk registers are used as a key business planning tool supporting service delivery.

Incident reporting enables the Trust to understand and manage risks associated with patients and staff. Incidents, investigation outcomes and trends are reviewed and discussed at service level and reported to the Quality and Performance Executive Committee with Board level scrutiny undertaken by the Finance, Investment and Performance, Audit and Quality Assurance Committees. Reporting trends are monitored to ensure all services in the Trust are reporting and if concerns are raised staff are reminded of their responsibility to report. As learning outcomes are shared across the organisation staff can see the value of reporting and the resulting change.

As a Trust the Board of Directors is accountable to the Council of Governors. The Trust's Council comprises a mix of appointed and publicly elected Governors. The Board provides the Council with information on key strategic risks and performance at each Council meeting. In addition, the Trust reports all Serious Incidents to our local systems and works with Local Authority Health Overview and Scrutiny Committees and Health and Wellbeing Boards to address issues raised by the public and/or local councillors.

The Trust has mechanisms in place to assure the Trust Board that workforce issues are a focus and priority.

Each month key workforce data including turnover, vacancies, sickness, appraisals, and training are reported to the Executive Quality and Performance Committee and the reports from this meeting are reviewed at the Finance, Investment & Performance sub-committee of the Board. The Board also receives a six-monthly report on formal HR processes including disciplinary and grievance activity.

Alongside workforce metrics, committees also review the monthly ward Safe Staffing report, which outlines our safer staffing requirements and workforce deployed against that requirement, as well as a declaration from the Director of Nursing and Therapies. An incident reporting system is used to report risks from reduced ward staffing and processes are in place to support escalation and actions to mitigate risk. Any changes to staffing and skill-mix in any services are supported by a QIA. Every six months a detailed safe staffing report is presented to the Quality and Performance Executive Committee and the Board, this report details use of evidence-based tools (where they exist), professional judgement, outcomes alongside other staff and workforce data to provide a triangulated view of safe staffing on the wards.

The Finance, Investment and Performance Board sub-committee receives updates on progress against the Trust's People Strategy and further to this a biannual report is submitted to the Trust Board covering key elements of the People Strategy, and progress on actions. The Deputy Chief Executive and Director of People attend the Board to present the report and take any questions, feedback, and respond to concerns. The People Strategy covers all aspects of the workforce, and the report explains what we are doing today to resolve current issues, and what the plans are for managing longer term issues and those priority areas identified in the NHS Long term Plan and the workforce risk on the Board Assurance Framework.

The Board Assurance Framework captures the risks associated with the workforce and currently identifies the recruitment and retention of the workforce as a key priority. This risk is discussed at the monthly Strategic People Group, attended by Divisional Directors and some Service Leads. The risks are discussed, and mitigations are agreed and reported back through Executive Committee to the Trust Board.

The Trust has a dedicated Workforce Planning and Temporary Staffing Lead whose role is to ensure that we have safe levels of staffing; that we respond to planned and unplanned workforce challenges and can deploy fixed and temporary staffing effectively and to work with services to continue to monitor and review roles and skills mix to ensure the most effective use of available resources. We use the workforce projections in our annual plan and known workforce movements to inform our Trust recruitment plan to proactively identify possible workforce gaps and better support safe staffing.

The Board has appointed a Non-Executive Wellbeing Guardian to provide scrutiny and assurance to the work of the Trust in support of our staff and the requirements of the NHS People plan.

The Trust is fully compliant with the registration requirements of the Care Quality Commission.

The Trust has published on its website an up-to-date register of interests, including gifts and hospitality, for decision-making staff (as defined by the Trust with reference to the guidance) within the past twelve months as required by the *Managing Conflicts of Interest in the NHS* guidance.

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with.

The Trust has undertaken risk assessments on the effects of climate change and severe weather and has developed a Green Plan following the guidance of the Greener NHS programme. The Trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

Review of Economy, Efficiency, and Effectiveness of the Use of Resources

The Board of Directors receives a report on key driver and tracker metrics at its formal public meetings. These metrics cover service activity, quality, patient safety, workforce, and cost as well as the patient experience.

The Finance, Investment & Performance sub-committee of the Board scrutinises this financial and performance information in detail on a regular basis, providing further assurance to the Board of Directors.

The Quality Executive committee reviews and scrutinises monthly non-financial performance and signals where further work needs to be undertaken to understand the data and/or improve performance. Whilst the monthly Business, Finance & Strategy Executive Committee performs the same for financial performance. The Divisional Performance, Safety & Quality review meetings chaired by Divisional Clinical Directors, review service performance routinely and drill down to individual service lines.

The above system ensures that the Trust performs within the agreed parameters of economy, efficiency and effectiveness and should those parameters be breached, is able to quickly identify issues and put in place plans to improve performance.

Through the audit programme internal and external audit provide further external assurance to the Board on economy, efficiency, and effectiveness of use of resources.

Information Governance

The Trust had two incidents in the 2023/24 period which were reportable to the ICO based on the impact.

The first incident involved a training guide created and published by a service for use of their clinical record system by Trust staff. For some elements of the guide screenshots were taken from the live system using identifiable patient records instead of from the test system which contains fictitious records. A member of staff recognised the details of a colleague in this guide exposing that they were known to the service and disclosing demographic information about them, this caused significant distress to the individual. The service removed and recalled all copies of the guide containing real personal data issuing a new version with fictitious information. The service have undertaken a full review of how guides are created by their team and shared this process, including the need for review and sign off before publication, with all staff to ensure only the test system is used to create this documentation.

The second incident involved a member of staff inappropriately accessing the records of a Trust client on multiple occasions as well as contacting a Trust service the client is known to without disclosing the nature of their relationship. The member of staff has a personal relationship with the client and there was no legitimate professional relationship for records to be access or information to be received under. Due to the circumstances and vulnerabilities of the client this case was referred to HR and a full investigation is currently in process.

The Trust continues to support services reporting breaches of all severity levels, the Information Governance Team review and grade all breaches and for those which are not notifiable to the ICO the local teams manage review, actions and learning from these with the IG Team monitoring any reoccurring breach types as teams and individuals making repeat breaches to take appropriate supportive action as required.

Data Quality and Governance

The Trust takes a number of steps to assure the Board that there are appropriate controls in place to ensure the accuracy of its data:

- The Chief Financial Officer is responsible for data quality processes and assurance.
- The Board and Executive level integrated performance report is underpinned by data recording and monitoring systems.
- The governance of data quality is overseen by the Audit Committee and Quality & Performance Executive Committee, which reviews improvement progress in the Trust's Information Assurance Framework.
- The Information Assurance Framework identifies the critical local and national performance indicators across safety, quality, and finance that governance committees of the Trust require data quality assurance of.

- The framework oversees a quarterly process of data source assurance and in-depth data quality audits undertaken by our internal data quality team, with feedback and improvement action followed up to improve completeness and accuracy of data.

- Internal team reviews are supplemented by internal and external audit reviews of data quality.

- The Trust is very high scoring on the national data quality maturity index for Trusts collected and returned data via national minimum datasets.

- Staff using Trust information systems to record data are trained and supervised in the use of systems and accurate and timely recording, supported by policies and operating procedures.

The Board and senior management team gains further assurance on service quality via visits to divisions to review delivery of the quality agenda and reviewing feedback from patient and staff surveys, safety, and outcome reports to Trust Board.

Waiting times are a national and organisational priority that are included in the annual plan. The Trust has an assurance process in place which focuses on the national and mandated targets and standards. These feature in the Trust Performance Report and are part of an audit schedule. This comprises of one of two levels of assurance validated calculation based on the data and record level audit to assess compliance. The Quality and Performance Executive Group receives and reviewed the monthly waiting times report which highlights services with longer waits and links to the quality concerns register. There are a number of services that do not have either local (commissioner or internally allocated) targets and work is underway with these services to improve reporting and data quality issues.

Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS Foundation Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit Committee and Quality Assurance Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

Assurance is informed by established processes to ensure the effectiveness of the systems of internal control supported by:

- Regular review of strategic-level risks and the BAF by the Executive, Audit Committee, Finance and Investment Board sub-committee and the Board of Directors, strengthen by positive assurance rating provided by Internal Audit on arrangements for risk management and our BAF.

- Audit Committee, chaired by a Non-Executive Director, meeting regularly, and delivering its agreed Audit plan, and maintaining a senior oversight of the activity of Board sub committees within the Trust's governance structure.

- Quality Assurance Committee, chaired by a non-executive director, meeting regularly, and ensuring monitoring and ongoing compliance with its fundamental standards for quality and safety and clinical outcomes and effectiveness.

- The Business, Finance & Strategy Executive Committee and Executive oversight of the Governance structure.

- Executive responsibility for the delivery of effectiveness, efficiency, and economy.

- Detailed processes undertaken by the Executive to verify compliance with CQC registration and NHS Foundation Trust Licence Conditions.

- Review of feedback from Staff and Patient Surveys

- Reviews of serious incidents requiring investigation and whistleblowing investigations and the outcome of the investigations.

- Assessment of key findings of external enquiries

I am further assured by the external assessment of our organisation, reflected in the attainment of 'Outstanding' overall core services rating from the November 2019 CQC inspection, and 'Outstanding' for Well Led and our NHS England's NHS Oversight Framework Segmentation of '1'.

The Trust's internal auditors, RSM have provided the following positive Head of Internal Audit Opinion for the 12 months ended 31st March 2024:

"The organisation has an adequate and effective framework for risk management, governance, and internal control. However, our work has identified further enhancements to the framework of risk management, governance, and internal control to ensure that it remains adequate and effective".

In providing this positive opinion RSM did not highlight any issues that needed to be reported in this governance statement.

The Trust and RSM have undertaken a range of reviews of financial, clinical, and operational issues during the year including Board assurance framework & corporate risk register and mandatory Information governance audits.

Audit recommendations are reviewed by the Audit Committee and are implemented according to an agreed timescale. Regular reviews are undertaken by the internal auditors to ensure any actions have been delivered as agreed.

Conclusion

No significant internal control issues have been identified by the Trust in 2023/24, and the Trust's Annual Governance Statement is a balanced reflection of the management position throughout the year.

Julian Emms, Chief Executive
18th June 2025

INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS OF BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST

Opinion

We have audited the financial statements of Berkshire Healthcare NHS Foundation Trust for the year ended 31 March 2025 which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows, the Statement of changes in equity and the related notes 1 to 23, including a summary of significant accounting policies.

The financial reporting framework that has been applied in their preparation is applicable law and UK adopted International Financial Reporting Standards as interpreted and adapted by the HM Treasury's Financial Reporting Manual: 2024-25 as contained in the Department of Health and Social Care Group Accounting Manual 2024 to 2025 and the Accounts Direction issued by NHS England with the approval of the Secretary of State as relevant to the National Health Service in England.

In our opinion the financial statements:

- give a true and fair view of the financial position of Berkshire Healthcare NHS Foundation Trust as at 31 March 2025 and of Foundation Trust's income and expenditure for the year then ended;
- have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2024 to 2025; and
- have been properly prepared in accordance with the National Health Service Act 2006.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the Auditor's responsibilities for the audit of the financial statements section of our report. We are independent of the Foundation Trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard and the Comptroller and Auditor General's AGN01, and we have fulfilled our other ethical responsibilities in accordance with these requirements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Conclusions relating to going concern

In auditing the financial statements, we have concluded that the Accounting Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on Foundation Trust's ability to continue as a going concern for a period of 12 months to 30 June 2025.

Our responsibilities and the responsibilities of the Accounting Officer with respect to going concern are described in the relevant sections of this report. However, because not all future events or conditions can be predicted, this statement is not a guarantee as to the Foundation Trust's ability to continue as a going concern.

Other information

The other information comprises the information included in the annual report, other than the financial statements and our auditor's report thereon. The Accounting Officer is responsible for the other information contained within the annual report.

Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in this report, we do not express any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the course of the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements themselves. If, based on the work we have performed, we conclude that there is a material misstatement of the other information, we are required to report that fact. We have nothing to report in this regard.

Opinion on other matters prescribed by the Code of Audit Practice

In our opinion:

- other information published together with the audited financial statements is consistent with the financial statements; and

- the parts of the Remuneration Report and Staff Report identified as subject to audit have been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2024/25.

Matters on which we are required to report by exception

The Code of Audit Practice requires us to report to you if:

- We issue a report in the public interest under schedule 10(3) of the National Health Service Act 2006;

- We refer the matter to the regulator under schedule 10(6) of the National Health Service Act 2006 because we have reason to believe that the Foundation Trust, or a director or officer of the Foundation Trust, is about to make, or has made, a decision involving unlawful expenditure, or is about to take, or has taken, unlawful action likely to cause a loss or deficiency;

- We are not satisfied that the Foundation Trust has put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources;

- We have been unable to satisfy ourselves that the Annual Governance Statement, and other information published with the financial statements meets the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual 2024/25 and is not misleading or inconsistent with other information forthcoming from the audit; or

- We have been unable to satisfy ourselves that proper practices have been observed in the compilation of the financial statements.

We have nothing to report in respect of these matters.

Responsibilities of the Accounting Officer

As explained more fully in the 'Statement of the Chief Executive's responsibilities as the accounting officer of Berkshire Healthcare NHS Foundation Trust' set out on page 130 the Chief Executive is the accounting officer of Berkshire Healthcare NHS Foundation Trust. The accounting officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view and for such internal control as the accounting officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the accounting officer is responsible for assessing the Foundation Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the Council of Governors intend to cease operations of the Foundation Trust, or have no realistic alternative but to do so.

As explained in the Governance Statement, the accounting officer is responsible for the arrangements to secure economy, efficiency and effectiveness in the use of the Foundation Trust's resources.

Auditor's responsibility for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements

Irregularities, including fraud, are instances of non-compliance with laws and regulations. We design procedures in line with our responsibilities, outlined above, to detect irregularities, including fraud. The risk of not detecting a material misstatement due to fraud is higher than the risk of not detecting one resulting from error, as fraud may involve deliberate concealment by, for example, forgery or intentional misrepresentations, or through collusion. The extent to which our procedures are capable of detecting irregularities, including fraud is detailed below. However, the primary responsibility for the prevention and detection of fraud rests with both those charged with governance of the entity and management.

- We obtained an understanding of the legal and regulatory frameworks that are applicable to the Trust and determined that the most significant are the National Health Service Act 2006, the Health and Social Care Act 2012 and the Health and Care Act 2022, as well as relevant employment laws of the United Kingdom. In addition, the Foundation Trust has to comply with laws and regulations in the areas of anti-bribery and corruption, data protection and health & safety. • We understood how Berkshire Healthcare NHS Foundation Trust is complying with those frameworks by understanding the incentive, opportunities and motives for non-compliance, including inquiring of management, head of internal audit and those charged with governance and obtaining and reviewing documentation relating to the procedures in place to identify, evaluate and comply with laws and regulations, and whether they are aware of instances of non-compliance. We corroborated this through our review of the Foundation Trust's board minutes, through enquiry of employees to verify Foundation Trust policies, and through the inspection of employee handbooks and other information. Based on this understanding we designed our audit procedures to identify non-compliance with such laws and regulations. Our procedures had a focus on compliance with the accounting framework through obtaining sufficient audit evidence in line with the level of risk identified and with relevant legislation.

- We assessed the susceptibility of the Foundation Trust's financial statements to material misstatement, including how fraud might occur by understanding the potential incentives and pressures for management to manipulate the financial statements, and performed procedures to understand the areas in which this would most likely arise. Based on our risk assessment procedures, we identified manipulation of reported financial performance (through improper recognition of revenue) and management override of controls to be our fraud risks.
- To address our fraud risk around the manipulation of reported financial performance through improper recognition of revenue, we reviewed the Foundation Trust's manual year end income accruals, challenging assumptions and corroborating the income to appropriate evidence.
- To address the presumed fraud risk of management override of controls, we implemented a journal entry testing strategy, assessed accounting estimates for evidence of management bias and evaluated the business rationale for significant unusual transactions. This included testing specific journal entries identified by applying risk criteria to the entire population of journals. For each journal selected, we tested specific transactions back to source documentation to confirm that the journals were authorised and accounted for appropriately.

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at https://www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

Scope of the review of arrangements for securing economy, efficiency and effectiveness in the use of resources

We have undertaken our review in accordance with the Code of Audit Practice 2024, having regard to the guidance on the specified reporting criteria issued by the Comptroller and Auditor General in November 2024, as to whether the Foundation Trust had proper arrangements for financial sustainability, governance and improving economy, efficiency and effectiveness. The Comptroller and Auditor General determined these criteria as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the Foundation Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2025.

We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary to form a view on whether, in all significant respects, the Foundation Trust had put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

We are required under schedule 10(1)(d) of the National Health Service Act 2006 to be satisfied that the Foundation Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. Under the Code of Audit Practice, we are required to report to you if the Foundation Trust has not made proper arrangement for securing economy, efficiency and effectiveness in the use of resources.

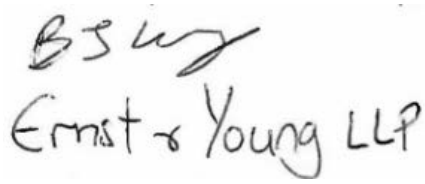
We are not required to consider, nor have we considered, whether all aspects of the Foundation Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

Delay in certification of completion of the audit

We cannot formally conclude the audit and issue an audit certificate until the NAO, as group auditor, has confirmed that no further assurances will be required from us as component auditors of the Foundation Trust.

Use of our report

This report is made solely to the Council of Governors of Berkshire Healthcare NHS Foundation Trust in accordance with Schedule 10 of the National Health Service Act 2006 and for no other purpose. Our audit work has been undertaken so that we might state to the Council of Governors those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors, for our audit work, for this report, or for the opinions we have formed.



Ben Lazarus (Key Audit Partner)

Ernst & Young LLP (Local Auditor)

London

19 June 2025

Statement of Comprehensive Income
For the Year ended 31 March 2025

	Note	2024/25 £000	2023/24 £000
Operating income from patient care activities	3	385,656	352,304
Other operating income	4	18,868	20,170
Total operating income from continuing operations		**404,524**	**372,474**
Operating expenses	5	(398,004)	(372,472)
Operating surplus / (deficit) from continuing operations		**6,520**	**2**
Finance income	8	3,370	3,228
Finance expenses	8.1	(4,956)	(9,631)
PDC dividends payable		0	(73)
Net finance costs		**(1,586)**	**(6,476)**
Gains / (Losses) of disposal of non-current assets	9	22	3
Surplus / (Deficit) for the year		**4,956**	**(6,471)**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	6	(3,472)	(38,716)
Revaluations		1,983	2,715
Other recognised gains and losses		0	0
Other reserve movements		(3)	(3)
Total other comprehensive income / (expenditure)		**(1,492)**	**(36,004)**
Total comprehensive income / (expense) for the period		**3,464**	**(42,475)**

Statement of Financial Position as at 31 March 2025

	Note	31 March 2025 £000	31 March 2024 £000
Non-current assets			
Intangible assets	10	1,623	1,836
Property, plant and equipment	11	80,565	78,917
Right of Use assets	12	12,772	15,221
Trade and other receivables	14	185	180
Total non-current assets		**95,145**	**96,154**
Current assets			
Inventories	13	323	312
Trade and other receivables	14	14,211	12,068
Cash and cash equivalents	15.1	53,968	52,612
Total current assets		**68,502**	**64,992**
Current liabilities			
Trade and other payables	16.1	(40,950)	(37,327)
Other liabilities	16.2	(10,930)	(11,113)
Borrowings	17	(6,690)	(6,205)
Provisions	18	(1,113)	(878)
Total current liabilities		**(59,683)**	**(55,523)**
Total assets less current liabilities		**103,964**	**105,623**
Non-current liabilities			
Borrowings	17	(49,865)	(54,872)
Provisions	18	(1,588)	(2,069)
Total non-current liabilities		**(51,453)**	**(56,941)**
Total assets employed		**52,511**	**48,682**
Financed by			
Public dividend capital		21,766	21,401
Revaluation reserve		20,677	22,019
Income and expenditure reserve		10,068	5,262
Total taxpayers' equity		**52,511**	**48,682**

The notes on pages 150 to 203 form part of these accounts

Name Julian Emms
Position Chief Executive Officer
Date 18th June 2025

Statement of Changes in Taxpayers' Equity for the year ended 31 March 2025

	Note	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' and others' equity at 1 April 2024 - brought forward		**21,401**	**22,019**	**5,262**	**48,682**
Comprehensive Income					
Surplus for the year				4,956	**4,956**
- Impairments	6	-	(3,472)	-	**(3,472)**
- Revaluations - property, plant & equipment			1,975		**1,975**
- Revaluations - right of use asset		-	8	-	**8**
Total Comprehensive Income		**-**	**(1,489)**	**4,956**	**3,467**
Public dividend capital received		365	-	-	**365**
Other reserve movements		-	147	(150)	**(3)**
Taxpayers' and others' equity at 31 March 2025		**21,766**	**20,677**	**10,068**	**52,511**

Statement of Changes in Equity for the year ended 31 March 2024

	Note	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' and others' equity at 1 April 2023 - brought forward		**21,136**	**58,020**	**31,628**	**110,784**
Comprehensive Income					
Application of IFRS 16 measurement principles to PFI liability on 1 April 2023				(19,891)	**(19,891)**
Surplus for the year				(6,471)	**(6,471)**
- Impairments	6	-	(38,716)	-	**(38,716)**
- Revaluations		-	2,715	-	**2,715**
Total Comprehensive Income		**-**	**(36,001)**	**(26,362)**	**(62,363)**
Public dividend capital received		265	-	-	**265**
Other reserve movements		-	-	(3)	**(3)**
Taxpayers' and others' equity at 31 March 2024		**21,401**	**22,019**	**5,262**	**48,682**

Information on reserves

Public dividend capital
Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS trust. Additional PDC may also be issued to NHS foundation trusts by the Department of Health and Social Care. A charge, reflecting the cost of capital utilised by the NHS foundation trust, is payable to the Department of Health and Social Care as the public dividend capital dividend.

Revaluation reserve
Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

Income and expenditure reserve
The balance of this reserve is the accumulated surpluses and deficits of the NHS foundation trust.

Statement of Cash Flows
For the Year ended 31 March 2025

	Note	2024/25 £000	2023/24 £000
Cash flows from operating activities			
Operating surplus		6,520	2
Non-cash income and expense:			
Depreciation and amortisation	5	11,054	10,839
Net impairments	6	302	6,938
Income recognised in respect of capital donations	4	-	(22)
(Increase)/Decrease in receivables and other assets		(3,796)	7,882
(Increase) in inventories		(11)	(24)
Increase/(Decrease) in trade and other payables		2,416	(11,033)
(Descrease)/Increase in other liabilities		(183)	471
(Decrease) in provisions		(40)	(541)
Other movements in operating cash flows		(3)	(3)
Net cash used in operating activities		16,259	14,509
Cash flows used in investing activities			
Interest received		3,370	3,228
Purchase of intangible assets		(266)	(471)
Purchase of property, plant, equipment and investment property		(9,986)	(9,324)
Receipt of cash donations to purchase capital assets		-	22
Net cash used in investing activities		(6,882)	(6,545)
Cash flows from financing activities			
Public dividend capital received		365	265
Capital element of finance lease rental payments		(2,733)	(2,570)
Capital element of PFI, LIFT and other service concession payments		(3,796)	(3,591)
Interest paid on finance lease liabilities		(217)	(125)
Interest paid on PFI, LIFT and other service concession obligations		(3,288)	(3,449)
PDC dividend refunded/(paid)		1,648	(1,078)
Net cash used in financing activities		**(8,021)**	**(10,548)**
Increase in cash and cash equivalents		**1,356**	**(2,584)**
Cash and cash equivalents at 1 April		**52,612**	**55,196**
Cash and cash equivalents at 31 March	15.1	**53,968**	**52,612**

NOTES TO THE ACCOUNTS

Note 1 Accounting policies and other information

1.1 Basis of preparation

NHS England has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2024/25 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

1.2 Standards, amendments and interpretations in issue but not yet effective or adopted

Accounting standards that have been issued but have not yet been adopted.

The Department of Health Government Accounting Manual (GAM) does not require the following Standards and Interpretations to be applied in 2024/25. These standards are still subject to HM Treasury FReM adoption, and are therefore not applicable to DH group accounts in 2024/25.

- ***IFRS 17 Insurance Contracts –*** The Standard is effective for accounting periods beginning on or after 1 January 2023. IFRS 17 has been adopted by the FReM from 1 April 2025. Adoption of the Standard for NHS bodies will therefore be in 2025/26. The Standard revises the accounting for insurance contracts for the issuers of insurance. Application of this standard from 2025/26 is not expected to have a material impact on the financial statements.
- ***IFRS 18 Presentation and Disclosure in Financial Statements*** - The Standard is effective for accounting periods beginning on or after 1 January 2027. The Standard is not yet UK endorsed and not yet adopted by the FReM. Early adoption is not permitted. The expected impact of applying the standard in future periods has not yet been assessed.
- ***IFRS 19 Subsidiaries without Public Accountability: Disclosures*** - The Standard is effective for accounting periods beginning on or after 1 January 2027. The Standard is not yet UK endorsed and not yet adopted by the FReM. Early adoption is not permitted. The expected impact of applying the standard in future periods has not yet been assessed.

  Changes to non-investment asset valuation – Following a thematic review of non-current asset valuations for financial reporting in the public sector, HM Treasury has made a number of changes to valuation frequency, valuation methodology and classification which are effective in the public sector from 1 April 2025 with a 5 year transition period. NHS bodies are adopting these changes to an alternative timeline.

  Changes to subsequent measurement of intangible assets and PPE classification / terminology to be implemented for NHS bodies from 1 April 2025:

  * Withdrawal of the revaluation model for intangible assets. Carrying values of existing intangible assets measured under a previous revaluation will be taken forward as deemed historic cost.

  * Removal of the distinction between specialised and non-specialised assets held for their service potential. Assets will be classified according to whether they are held for their operational capacity.

These changes are not expected to have a material impact on these financial statements.

Changes to valuation cycles and methodology to be implemented for NHS bodies in later periods:

* A mandated quinquennial revaluation frequency (or rolling programme) supplemented by annual indexation in the intervening years

* Removal of the alternative site assumption for buildings valued at depreciated replacement cost on a modern equivalent asset basis. The approach for land has not yet been finalised by HM Treasury.

The impact of applying these changes in future periods has not yet been assessed. PPE and right of use assets currently subject to revaluation have a total book value of £60.9m as at 31 March 2025. Of the total £60.9m, assets valued on an alternative site basis have a total book value of £46.8m at 31 March 2025.

The Foundation Trust will assess the impact of these standards after issue of the Annual Reporting Manual 2025/26 by NHS England.

1.2.1 Early adoption of standards, amendments and interpretations.

No new accounting standards or revisions to existing standards have been early adopted in 2024/25.

1.2.2 Prior Period Adjustments

In accordance with IAS 8 the Foundation Trust will record a prior period adjustment where there have been omissions from, and misstatements in, the Foundation Trust's financial statements for one or more prior periods arising information that:

- Was available when financial statements for those periods were authorised for issue and;
- Could reasonably be expected to have been obtained and taken into account in the preparation and presentation of those financial statements.

There have been no prior period adjustments in these accounts.

1.3 Critical accounting estimates and judgements

In the application of the Trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

Critical accounting judgements

- Income is derived by block contract from Integrated Care Boards, NHS England and the Unitary Authorities of Berkshire. All these contracts are subject to variations which may result in judgements being made by management on the timing and amount of income to be allocated to the correct financial reporting year. Other income is received for Education & Training and Research & Development, where the level of income recognised is subject to judgement made by management on the terms and conditions of those contracts and the expenditure which may not be evenly distributed through the financial year.

- In 2023/24, the Trust employed an independent consultancy to support the identification and development of an optimised 'alternative site' solution for a Modern Equivalent Asset ('MEA') model as the basis of a valuation for the Trust's two main inpatient sites at Prospect Park Hospital in Reading and West Berkshire Community Hosptial in Newbury. Both of these units operate under a Private Finance Initiative ('PFI') arrangement and are recognised as assets within Land and Buildings. Also included in the optimisation is a donated asset known as Greenham Trust Wing co-located on the West Berkshire Community Hospital site.

  The assumption made under an alternative site basis is that the number and scale of both sites would reduce if the buildings were co-located into a single site where the existing West Berkshire Community Hospital is currently situated. Optimisation has considered the current occupancy and usage in each location by patients and service users and the services being delivered at each location. A model has been established based on notional building sizes that would accommodate the services currently being delivered in two geographically dispersed locations.

- The West Berkshire Community Hospital site in Newbury is considered a suitable alternative site as the area provides good access to the Trust's population to hospital services being off the A4 and M4 motorway network and also the rail network. The Trust has previously successfully relocated services to a single site, when it transferred inpatient mental health facilities from Ascot and Wexham Park Hospital in East Berkshire to Prospect Park Hospital in Reading, so consideration for relocating services again to a single site in Newbury would be feasible subject to normal consultation with stakeholders.

  The valuations of the optimised PFI buildings is net of VAT as under PFI arrangements, VAT is fully recoverable under HM Treasury Contracted Out Service provisions. The valuation for the notional building relating to the donated asset is gross of VAT, as VAT is not expected to be recoverable, and which is consistent with the original costs of construction.

  The Trust considers the move to alternative site to be a change in estimation and therefore does not require restatement of the prior year comparator in accordance with IAS 8.

  Valuations for the alternative site were performed by an independent valuation specialist, Carter Jonas. An opening valuation was done for 2023/24, dated 1st April 2023, and subsequent revaluations were performed for year end on the 31st March 2024 and 31st March 2025. The revaluation on the 31st March 2025, resulted in a reduction of £3.0m from £49.8m on the 31st March 2024 to £46.8m on the 31st March 2025. Additional efficiences were identified in the Modern Equivalent Asset alternative site valuation model for the PFIs in respect of reductions in floor areas. There were no changes in occupancy or services being delivered between those two dates.

- The Right of Use assets and corresponding lease liability in respect of property leased from NHS Property Services Ltd has been determined based on the original formal lease arrangements that were in place for the period from 1st April 2011 to 31st March 2016. The Trust has not entered into new formal lease arrangements with NHS Property Services since the expiry of the original leases.

  The Governments financial reporting manual ('FreM') has applied a wider definition to cover intra-governmental arrangements that are not legally enforceable to ensure that all 'lease like' arrangements between governmental departments, whether they be formal or informal should be interpreted as being in scope for IFRS 16, on the basis that the arrangement is similar to a contract that is enforceable. On this basis the Trust has determined the lease arrangements with NHS Property Services as being included under IFRS 16 Leases with a lease term of 5 years being consistent with the original lease term.

  Following the expiry of the initial leases on the 31st March 2016, the Trust has deemed itself to be occupying NHS Property Service sites under the terms of the original expired 5 year leases.

- The original leases were contracted out of the security of tenure provisions of the Landlord & Tenant Act 1954. That means the Trust had no automatic right to new tenancies when the original leases expired. Had the Trust enjoyed the rights provided by the Landlord & Tenancy Act 1954, then the leases would have automatically continued and could not be terminated except by notice served under the Act. For the landlord, NHS Property Services, that would mean serving a S.25 Notice giving between 6-12 months' notice to terminate the lease. The Trust as tenant could also serve a notice called a S.26 Notice requesting a new tenancy.

The above is not applicable here because the Trust has continued to occupy and pay the same rent and other charges following expiry of the contracted-out leases. The Trust considers that it has implied periodic annual tenancies which run from year to year. Under these arrangements the Trust could serve notice to terminate leases so there is no more commitment than 3 months. The landlord could serve a notice to terminate, and that would be a S.25 Notice giving not less than 6 months' notice. In addition, the parties could agree to a surrender any or all of the existing lease interests if new lease terms were agreed in the future.

Strategically, the Trust currently has no immediate plans or objectives to vacate NHS Property Services sites although within the portfolio of property under a lease arrangement there may be minor changes to meet operational requirements, and which can occur at short notice happening in a period of less than one year. However, management has determined that for the purposes of estimating the value of the Right of Use assets and corresponding lease liability, it is reasonable to use a lease term consistent with the arrangements of the original lease that commenced in April 2011, especially as any lease renewal would likely be set for that minimum term of 5 years. NHS Property Services has not sought to end the existing tenancies or negotiate new lease agreements.

A sensitivity analysis of different lease terms of less than one year up to 10 years identifies that there is no net material impact on the Statement of Financial Position or Statement of Comprehensive Income in respect of applying alternate lease terms. Secondly, the impact on the Statement of Comprehensive Income indicates that there is no material difference for treating the NHS Property Services as a Right of Use asset under IFRS 16 or retaining it as an operating lease with rolling lease term of less than one year. Finally, the impact on cash under each scenario is negligible.

	Lease Term (Years)*			
	<1**	**3*****	**5******	**10*****
Statement of Financial Position - opening balance as at 1st April 2024				
RoU Asset	0	1,407	3,931	10,890
Lease Liability	0	(1,420)	(3,966)	(10,992)
Net Liability	**0**	**(13)**	**(35)**	**(102)**
Statement of Financial Position - closing balances as at 31st March 2025				
RoU Asset	0	0	2,697	9,529
Lease Liability	0	0	(2,687)	(9,663)
Net Liability	**0**	**0**	**10**	**(134)**
Statement of Comprehensive Income for year ended 31st March 2025				
Operating Lease Payments	1,425	0	0	0
Interest Charges	0	8	32	99
Depreciation	0	1,407	1,341	1,361
Total Charges to SoCI	**1,425**	**1,415**	**1,373**	**1,461**
Statement of CashFlow for year end 31st March 2025				
Payment of operating lease	(1,425)	0	0	0
Interest Charges	0	(8)	(35)	(99)
Repayment of Lease Liability	0	(1,420)	(1,383)	(1,329)
PDC Dividend	0	(0)	(1)	(4)
Net Impact on Cash	**(1,425)**	**(1,429)**	**(1,419)**	**(1,433)**

* Lease term calculated from 1st April 2022 which is transition date to IFRS 16
** Lease retained as operating lease and not transitioned to IFRS 16.
*** Values are indicative based on leases in force at the end of 2024/25
**** This is the actual lease impact per the year end accounts 2024/25

The opening valuation of the Right of Use asset for NHS Property Service leases on the date of transition to IFRS 16 on 1st April 2022 was £7.0m with a corresponding lease liability for £7.0m This was based on the annual rental payment payable for the financial year 2022/23. The Trust does not expect the rental charges to change for the five years up to 31st March 2027. The current net book value of NHS Property Service Right of Use assets as at the 31st March 2025 is £2.7m with a corresponding lease liability as at the same date of £2.7m. The Right of Use asset is being depreciated over a period of 5 years from 1st April 2022 to 31st March 2027 with the lease liability being repaid over the same period.

Key Sources of Estimation Uncertainty

The judgements and key sources of estimation uncertainty that have a significant effect on the material amounts recognised in the financial statements in the current or next financial year are detailed below:

- Asset valuations for land and buildings are provided on annual basis. Valuations are subject to general price changes in the property values across the UK. Asset values might vary from the real market value when assets are disposed. Total asset valuations as at 31st March 2025 was £60.9m (2023/24: £66.4m). The current valuation is net of fixed asset additions, less depreciation, less impairments, less disposals, plus any revaluation surplus.

  The three sites where the alternative site valuations were used for 2024/25 include West Berkshire Community Hospital in Newbury, Prospect Park Hospital in Reading, and the Greenham Trust Wing, co-located at the West Berkshire Community Hospital in Newbury.

  The alternative site valuation is based on three notional buildings being co-located to a single site in Newbury where the existing West Berkshire Community Hospital is situated with the land requirements and building size and scale that would accomodate all the Trusts existing services for community and mental health plus assocated admin support areas.

  At then end of financial year 2022/23 the valuations under a no alternative site valuation for the above sites was a total £92.7m split between land (£18.5m) and buildings (£74.3m).

  The move to alternative site valuation occured on the 1st April 2023. A valuation for the land and buildings on the 1st April 2023 resulted in a reduction in the valuation under MEA/DRC of land and buildings from £92.7m to £48.7m, made up of land (£4.5m) and buildings (£44.2m). The initial valuation to alternative site in April 2023 resulted in an impairment of £44.0m against the land and buildings in respect of the sites detailed above. This was split betwen land (£14.0m) and Buildings (£30.0m).

  A revaluation was performed on the 31st March 2025 for year end 2024/25 that decreased the valuation to £46.8m, made up of land (£4.5m) and buildings (£42.3m). This reduction was due to further efficiences being identified in the MEA alternative site valuation model.

  Subject to the proposed changes as highlighted in Note 1.2 Changes to non-investment asset valuation, future valuations will be based on changes in land and building prices as updated periodically. It is not feasible to predict future changes in valuations which are subject to future micro and macro-economic conditions prevailing at the time of the next revaluation.

- Determination of useful lives for property, plant and equipment - estimated useful lives for Trust's assets are based on common, widely used assumptions for each asset type except where specialist information is available from professional bodies. The Trust reviews these lives on a regular basis as part of the process to assess whether assets have been impaired. The range of useful lives ranges from 3 years for IT software, up to 90 years for Land and Buildings.

- Accruals are based on estimates and judgements of historical trends and anticipated outcomes. At the end of each accounting period, management review items that are outstanding and estimate the amount to be accrued in the closing financial statements of the Trust. Any variation between the estimate and the actual is recorded under the relevant heading within the accounts in the subsequent financial period. The total value of contract receivable accruals in respect of at the year end 31st March 2025 is £3.0m (2023/24: £2.5m); whilst payable accruals were £23.6m (2023/24: £21.5m) which includes an accrual for untaken annual leave of £1.2m (2023/24: £1.2m).

- Provisions for pension and legal liabilities including dilapidation estimates on property leases, are based on the information provided from NHS Pension Agency, NHS Resolution and the Trust's own sources. Pension provision is based on the estimated life expectancy of the individual pensioner as stated in the UK Actuarial Department most recent life tables which change annually. All provisions are estimates of the actual costs of future cash flows and are dependent on future events. Any differences between expectations and the actual future liability will be accounted for in the period when such determination is made. The total value of provisions at the year end 31st March 2025 is £2.7m (2023/24: £2.9m).

1.4 Going Concern

These accounts have been prepared on a going concern basis. The financial reporting framework applicable to NHS bodies, derived from the HM Treasury Financial Reporting Manual, defines that the anticipated continued provision of the entity's services in the public sector is normally sufficient evidence of going concern. The directors have a reasonable expectation that this will continue to be the case.

After making enquiries, the directors have a reasonable expectation that the services provided by the Trust will continue to be provided by the public sector for the foreseeable future and until 30th June 2026 i.e. 12 months after the publication of the annual report and accounts for 2024/25. Management's enquiries covered planning, allocations, capital planning, policy on NHS structures and Trust strategy. The following points support the adoption of the going concern basis:

* There are no local or national policy decisions that are likely to affect that continued funding and provision of services by the Trust;
* The Trust's financial position in 2024/25 was a £5m surplus. This is adjusted to a £4.9m surplus for the purposes of assessing the Trust's performance. Adjusted performance is consistent with 2023/2024, 2022/23, and 2021/22 where surpluses were also delivered;
* In 2024/25 the Trust has continued to benefit from the block contract arrangements for most of the income from Integrated Care Boards. These arrangements have provided certainty on income and improved liquidity and cash flow;
* The Trust Board has approved a plan for 2025/26 and this has been submitted to NHS England by the Trust and as part of the submission made by Buckinghamshire, Oxfordshire and Berkshire West ICS, of which the Trust is a member. The plan is for a surplus of £1.7m. The plan assumes income as agreed with the Trust's main NHS and non-NHS commissioners and is based on planning guidance assumptions. The plan includes a requirement to deliver a £17.6m efficiency programme which equates to 4.5% of the Trust's turnover. The efficiency programme is fully identified but includes some stretch targets around temporary staffing and corporate savings. The Trust's 2025/26 plan covers revenue, capital, cash, workforce and activity;
* The Trust has a rolling cash flow forecast based on expectations for funding and this extends to the end of July 2026. This indicates that the Trust would be able to continue to operate with good levels of liquidity for revenue and capital purposes, with no requirement to undertake borrowing and with a cash balance of £42.3m at the end of July 2026.

Based on management enquiries and the points made above, the directors have concluded that the going concern basis should be adopted in preparation of these accounts and in following the definition of going concern in the public sector adopted by HM Treasury's Financial Reporting Manual.

1.5 Revenue from contracts with customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS).

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where the Trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

The Trust receives the majority of its income from customers on a block contract arrangement which means that payments against the contract are received equally in twelfths across the financial year and which is not directly linked to specific satisfaction of performance obligations.

Revenue from NHS Contracts

The main source of income for the Trust is contracts with commissioners for health care services. Funding envelopes are set at an Integrated Care System (ICS) level. The majority of the Trust's income is earned from NHS commissioners in the form of fixed payments to fund an agreed level of activity.

2024/25

The main source of income for the Trust is contracts with commissioners for health care services. In 2024/25, the majority of the Trust's income from NHS commissioners was in the form of block contract arrangements. The block contract funding was received from the Integrated Care Boards, that were established from the 1st July 2022. The Trust's entitlement to the consideration under the block contract did not vary regardless of the activity performed and the performance obligation continued to be the delivery of healthcare and related services.

Aligned payment and incentive contracts form the main payment mechanism under the NHS Payment Scheme. In 2024/25 API contracts contain both a fixed and variable element. Under the variable element, providers earn income for elective activity (both ordinary and day case), out-patient procedures, and out-patient first attendances. The precise definition of these activities is given in the NHS Payment Scheme. Income is earned at NHSPS prices based on actual activity. The fixed element includes income for all other services covered by the NHSPS assuming an agreed level of activity with 'fixed' in this context meaning not varying based on units of activity. Elements within this are accounted for as variable consideration under IFRS 15 as explained below.

Elective recovery funding provides additional funding to integrated care boards to fund the commissioning of elective services within their systems. In 2024/25, trusts do not directly earn elective recovery funding, instead earning income for actual activity performed under API contract arrangements as explained above. The level of activity delivered by the trust contributes to system performance and therefore the availability of funding to the trust's commissioners.

Comparative period 2023/24

The main source of income for the Trust is contracts with commissioners for health care services. In 2023/24, the majority of the Trust's income from NHS commissioners was in the form of block contract arrangements. The Trust received block funding from Integrated Care Boards. The Trust's entitlement to the consideration under the block contract did not vary regardless of the activity performed and the performance obligation continued to be the delivery of healthcare and related services.

The Trust received additional income outside of the block and system envelopes to reimburse specific costs incurred and other income top-ups to support the delivery of services. Reimbursement and top-up income was accounted for as variable consideration.

NHS injury cost recovery scheme

The Trust receives income under the NHS injury cost recovery scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, for instance by an insurer. The Trust recognises the income when performance obligations are satisfied. In practical terms this means that treatment has been given, it receives notification from the Department of Work and Pension's Compensation Recovery Unit, has completed the NHS2 form and confirmed there are no discrepancies with the treatment. The income is measured at the agreed tariff for the treatments provided to the injured individual, less an allowance for unsuccessful compensation claims and doubtful debts in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset.

Apprenticeship service income

The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider from the Trust's Digital Apprenticeship Service (DAS) account held by the Department for Education, the corresponding notional expense is also recognised at the point of recognition for the benefit.

Other Operating Income

The Trust receives income from other sources which is not directly related to the delivery of healthcare services. This includes income to support training and development of staff; managed estates services; property rental; and crèche services. Income is also recognised in respect of donations received for the purchase of capital assets or contributions to expenditure. Other operating income is recognised on an accruals basis when the delivery of the activity has occurred.

1.6 Expenditure on Employee Benefits

Short-term Employee Benefits

Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees.

Annual Leave Entitlement

The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period. The permitted carry forward is five days except in exceptional circumstances where an employee is on maternity or long-term sickness absence.

Pension costs

NHS Pension Scheme

Past and present employees are covered by the provisions of the NHS Pension Schemes. Details of the benefits payable and rules of the schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both the 1995/2008 and 2015 schemes are accounted for, and the scheme liability valued, as a single combined scheme. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years".

An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2025, is based on valuation data as at 31 March 2023, updated to 31 March 2025 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the Statement by the Actuary, which forms part of the annual NHS Pension Scheme Annual Report and Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (considering recent demographic experience), and to recommend the contribution rate payable by employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2020. The results of this valuation set the employer contribution rate payable from 1 April 2024 to 23.7% of pensionable pay. The core cost cap cost of the scheme was calculated to be outside of the 3% cost cap corridor as at 31 March 2020. However, when the wider economic situation was taken into account through the economic cost cap cost of the scheme, the cost cap corridor was not similarly breached. As a result, there was no impact on the member benefit structure or contribution rates.

The 2024 actuarial valuation is currently being prepared and will be published before new contribution rates are implemented from April 2027.

National Employment Savings Trust ('NEST')

In 2014/15, the Trust implemented auto-enrolment for eligible employees in the National Employment Savings Trust ('NEST'), which is a scheme set up under the Pensions Act 2008. NEST is regulated by The Pensions Regulator the UK regulator of workplace pension schemes.

NEST is a defined contribution, off Statement of Financial Position scheme. The value of employer contributions in 2024/25 was £35K (2023/24: £49K).

1.7 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

1.8 Property, Plant and Equipment

Recognition

Property, Plant and Equipment is capitalised where:

it is held for use in delivering services or for administrative purposes;

it is probable that future economic benefits will flow to, or service potential be provided to, the Trust;

it is expected to be used for more than one financial year; and

the cost of the item can be measured reliably.

In addition, for Property, Plant and Equipment to be capitalised must:

individually have a cost of at least £5,000; or

form a group of assets which individually have a cost of more than £250, collectively have a cost of at least £5,000, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or

form part of the initial setting-up cost of a new building or refurbishment, irrespective of their individual or collective cost.

Where a large asset, for example a building, includes a number of components with significantly different asset lives e.g. plant and equipment, then these components are treated as separate assets and depreciated over their own useful economic lives.

Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Measurement

Valuation

All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

Assets are measured subsequently at valuation. Assets which are held for their service potential and are in use (i.e. operational assets used to deliver either front line services or back office functions) are measured at their current value in existing use. Assets that were most recently held for their service potential but are surplus with no plan to bring them back into use are measured at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

As land and buildings are reported separately in the notes to the Statement of Financial Position (SoFP), impairments and revaluations need to be analysised between land and buildings, based on the valuer's analysis of the overall valution of the property and upwards revaluations or impairments need to be recognised seperately on land and buildings.

The review of valuations for land and buildings including two PFI properties is performed by Carter Jonas, which is a independent commercial valuation provider.

Valuations are reviewed on the 31st March of each calendar year, with a full physical inspection every five years, an interim physical verification at three years and a desktop review in all other years. The last full physical inspection for all land and buildings including the PFIs was performed during 2022/23 in preparation for the year ending on 31st March 2023.

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying values are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

Current values in existing use are:

- Land and non-specialised buildings – market value for existing use; and
- Specialised buildings – depreciated replacement cost on a modern equivalent asset basis.

For specialised assets, current value in existing use is interpreted as the present value of the asset's remaining service potential, which is assumed to be at least equal to the cost of replacing that service potential. Specialised assets are therefore valued at their depreciated replacement cost (DRC) on a modern equivalent asset (MEA) basis. An MEA basis assumes that the asset will be replaced with a modern asset of equivalent capacity and meeting the location requirements of the services being provided. Assets held at depreciated replacement cost have been valued on an alternative site basis where this would meet the location requirements.

The Trust's operational land and buildings assets that include the two PFIs of West Berkshire Community Hospital, Newbury and Prospect Park Hosptial, Reading, are valued on the basis that a modern equivalent asset would take the form of a single site in existing Newbury location that would be suitable for delivery of the Trust's services based on analysis of the population served by the Trust. In calculating the cost of this Modern Equivalent Asset, the Trust and the valuer have had regard to both the nature and size of the facilities that would be required. The valuer has taken the present area of the Trust's land and buildings as the baseline figure but has excluded areas which are not relevant for the comparison (such as courtyards or unused spaces).

Valuation guidance issued by the Royal Institute of Chartered Surveyors states that valuations are performed net of VAT where the VAT is recoverable by the entity. This basis has been applied to the Trust’s Private Finance Initiative (PFI) scheme where the construction is completed by a special purpose vehicle and the costs have recoverable VAT for the Trust.

A formal revaluation is required every 5 years with an interim formal valuation in the third year of each cycle. A Modern Equivalent Asset Optimised Alternative Site valuation was undertaken as at 1st April 2023 by the Trust's independent valuer. A further desktop valuation was undertaken as at 31 March 2025 for the year end valuation by the Carter Jonas.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees and, where capitalised in accordance with IAS 23, borrowings costs. Assets are revalued and depreciation commences when the assets are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful lives or low values or both, as this is not considered to be materially different from current value in existing use.

Revaluation surpluses and impairments due to changes in valuations are reflected in Other Comprehensive Income in the Statement of Comprehensive Income, the Statement of Changes in Taxpayers Equity and Notes 6 Impairments and 11.1 Property, Plant and Equipment.

The value of land for existing use purposes is assessed at existing use value. For non-operational properties including surplus land, the valuations are carried out at open market value.

An item of property, plant and equipment which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 of IFRS 5.

For all categories of non-property assets, the Trust considers that depreciated historical cost is an acceptable proxy for current value in existing use, as the useful economic lives used are considered to be a realistic reflection of the lives of assets and the depreciation methods used reflect the consumption of the asset.

Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Revaluation and impairment

Land and buildings are fully revalued every five years with an interim revaluation every financial year. All revaluations are performed by a professional qualified valuer who is a member of the Royal Institute of Chartered Surveyors.

Further revaluations may be done at any other time particularly where there have been additions, dilapidation or part disposal of an asset or on the occurrence of an event likely to cause impairment.

Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse an impairment previously recognised in operating expenses, in which case they are recognised in operating income.

Decreases in asset values and impairments are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of ‘other comprehensive income’.

In accordance with the GAM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating income to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised. Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

Depreciation

Items of Property, Plant and Equipment are depreciated over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

The standard useful life for Property, Plant and Equipment held by the NHS foundation trust is:

- Buildings (excluding dwellings): 35 years
- Furniture & Fittings: 7 years
- Transport Equipment: 7 years
- Plant & Machinery: 5 years
- Information Technology: 4 years
- Software and Licenses: 3 years

Where there is a valid and reasonable expectation of the Trust that the economic useful life of Property Plant or Equipment is different to the standard, this will be assessed on a case by case basis taking into account the materiality of the initial investment and expected timing for replacement. The useful life will then be adjusted accordingly.

Property, Plant and Equipment which has been reclassified as 'Held for Sale' ceases to be depreciated upon the reclassification. Assets in the course of construction are not depreciated until the asset is brought into use.

De-recognition

Assets intended for disposal is reclassified as 'Held for Sale' once all of the following criteria are met:

- The asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
- the sale must be highly probable i.e. management are committed to a plan to sell the asset;
- a programme has begun to find a buyer and complete the sale;
- the asset is being actively marketed at a reasonable price;
- the sale is expected to be completed within 12 months of the date of classification as 'Held for Sale'; and,
- the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

The profit or loss arising on disposal of an asset is the difference between the sale proceeds and the carrying amount and is recognised in the Statement of Comprehensive Income. On disposal, the balance for the assets on the revaluation reserve is transferred to Income and Expenditure reserve. For donated assets, a transfer is made to or from the relevant reserve to the profit/loss on disposal amount so that no profit or loss is recognised in income and expenses. The remaining surplus or deficit in the donated asset reserve is then transferred to Income and Expenditure reserve.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'Held for Sale' and instead is retained as an operational asset and the asset's economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

1.9 Donated and grant funded assets

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

1.10 Government grants

Government grants are grants from government bodies other than revenue from NHS bodies for the provision of services. Revenue grants are treated as deferred income initially and credited to income to match the expenditure to which they relate. Capital grants are treated as income and the receipt credited to the Statement of Comprehensive Income. The associated asset is treated in a manner consistent with the depreciation and impairment charges for that asset. Assets purchased from government grants are valued, depreciated and impaired as described above for purchased assets. Gains and losses on revaluations and impairments are taken to the revaluation reserve and, each year, an amount equal to the depreciation charge on the asset charged to the Statement of Comprehensive Income.

A grant for an asset may be received subject to a condition that it is to be returned to the grantor if a specified future event does or does not occur. For example, a grant may need to be returned if the foundation trust ceases to use the asset purchased with that grant for a purpose specified by the grantor. In these cases, a return obligation does not arise until such time as it is expected that the condition will be breached and a liability is not recognised until that time. Such a condition would not therefore require the grant to be treated as deferred.

1.11 Private Finance Initiative (PFI) transactions

PFI transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's FReM, are accounted for as 'on-Statement of Financial Position' by the Trust. In accordance with HM Treasury's FReM, the underlying assets are recognised as property, plant and equipment, together with an equivalent liability. Subsequently, the assets are accounted for as property, plant and equipment and/or intangible assets as appropriate.

Subsequent measurement

Assets are subsequently accounted for as property, plant and equipment and/or intangible assets as appropriate.

The liability is subsequently reduced by the portion of the unitary charge allocated as payment for the asset and increased by the annual finance cost. The finance cost is calculated by applying the implicit interest rate to the opening liability and is charged to finance costs in the Statement of Comprehensive Income. The element of the unitary charge allocated as payment for the asset is split between payment of the finance cost and repayment of the net liability.

Where there are changes in future payments for the asset resulting from indexation of the unitary charge, the Trust remeasures the PFI liability by determining the revised payments for the remainder of the contract once the change in cash flows takes effect. The remeasurement adjustment is charged to finance costs in the Statement of Comprehensive Income.

The service charge is recognised in operating expenses in the Statement of Comprehensive Income.

Application of IFRS 16 liability measurement principles to PFI and LIFT liabilities

IFRS 16 liability measurement principles were applied to PFI, LIFT and other service concession arrangement liabilities from 1 April 2023. The change in measurement basis was applied using a modified retrospective approach with the cumulative impact of remeasuring the liability on 1 April 2023 recognised in the income and expenditure reserve.

Comparatives for PFI, LIFT and other service concession arrangement liabilities were not restated on an IFRS 16 basis, as required by the DHSC Group Accounting Manual. Under IAS 17 measurement principles which applied in 2022/23 and earlier, movements in the liability were limited to repayments of the liability and the annual finance cost arising from application of the implicit interest rate. The cumulative impact of indexation on payments for the asset was charged to finance costs as contingent rent as incurred.

Lifecycle replacements

Components of the assets replaced by the operator during the contract are capitalised where they meet the Trust's criteria for capital expenditure. They are capitalised at the time they are provided by the operator and are measured initially at their fair value.

The element of the annual unitary payment allocated to lifecycle replacement is pre-determined for each year of the contract from the operator’s planned programme of lifecycle replacement. Where the lifecycle component is provided earlier or later than expected, a short-term finance lease liability or prepayment is recognised respectively.

Where the fair value of the lifecycle component is less than the amount determined in the contract, the difference is recognised as an expense when the replacement is provided. If the fair value is greater than the amount determined in the contract, the difference is treated as a ‘free’ asset and a deferred income balance is recognised. The deferred income is released to the operating income over the shorter of the remaining contract period or the useful economic life of the replacement component.

Assets contributed by the Trust to the operator for use in the scheme:

Assets contributed for use in the scheme continue to be recognised as items of property, plant and equipment in the Trust’s Statement of Financial Position.

Other assets contributed by the Trust to the operator:

Assets contributed (e.g. cash payments, surplus property) by the Trust to the operator before the asset is brought into use, which are intended to defray the operator’s capital costs, are recognised initially as prepayments during the construction phase of the contract. Subsequently, when the asset is made available to the Trust, the prepayment is treated as an initial payment towards the finance lease liability and is set against the carrying value of the liability.

1.12 Intangible Assets

Recognition

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the Trust's business or which arise from contractual or other legal rights They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the Trust and where the cost of the asset can be measured reliably.

Internally generated intangible assets.

Expenditure on research is not capitalised.

Expenditure on internally generated assets is capitalised only where all of the following can be demonstrated:

- the project is technically feasible to the point of completion and will result in an intangible asset for sale or use;
- the Trust intends to complete the asset and sell or use it;
- the Trust has the ability to sell or use the asset;
- how the intangible asset will generate probable future economic or service delivery benefits e.g. the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset:
- adequate financial, technical and other resources are available to the Trust to complete the development and sell or use the asset; and
- the Trust can measure reliably the expenses attributable to the asset during development.

Software

Software which is integral to the operation of hardware e.g. an operating system is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware e.g. application software, is capitalised as an intangible asset.

Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 of IFRS 5.

Intangible assets held for sale are measured at the lower of their carrying amount or 'fair value less costs to sell'.

For all categories of intangible assets, the Trust considers that depreciated historical cost is an acceptable proxy for current value in existing use, as the useful economic lives used are considered to be a realistic reflection of the lives of assets and the depreciation methods used reflect the consumption of the asset.

Amortisation

Intangible assets are amortised over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. The expected useful life for software is 3 years.

1.13 Inventories

Inventories are valued at the lower of cost and net realisable value using the weighted average cost formula. This is considered to be a reasonable approximation to fair value due to the high turnover of stocks.

1.14 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust's cash management.

Cash and bank balances are recorded at current values.

1.15 Leases

A lease is a contract or part of a contract that conveys the right to use an asset for a period of time in exchange for consideration. An adaptation of the relevant accounting standard by HM Treasury for the public sector means that for NHS bodies, this includes lease-like arrangements with other public sector entities that do not take the legal form of a contract. It also includes peppercorn leases where consideration paid is nil or nominal (significantly below market value) but in all other respects meet the definition of a lease. the Trust does not apply lease accounting to new contracts for the use of intangible assets.

The Trust as a lessee

Recognition and initial measurement

At the commencement date of the lease, being when the asset is made available for use, the Trust recognises a right of use asset and a lease liability.

The right of use asset is recognised at cost comprising the lease liability, any lease payments made before or at commencement, any direct costs incurred by the lessee, less any cash lease incentives received. It also includes any estimate of costs to be incurred restoring the site or underlying asset on completion of the lease term.

The lease liability is initially measured at the present value of future lease payments discounted at the interest rate implicit in the lease. Lease payments includes fixed lease payments, variable lease payments dependent on an index or rate and amounts payable under residual value guarantees. It also includes amounts payable for purchase options and termination penalties where these options are reasonably certain to be exercised.

Where an implicit rate cannot be readily determined, the Trust's incremental borrowing rate is applied. This rate is determined by HM Treasury annually for each calendar year. A nominal rate of 4.72% applied to new leases commencing in 2024 and 4.81% to new leases commencing in 2025.

Lease payments are apportioned between finance charges and repayment of the principal. Finance charges are recognised in the Statement of Comprehensive Income.

The Trust does not apply the above recognition requirements to leases with a term of 12 months or less or to leases where the value of the underlying asset is below £5,000, excluding any irrecoverable VAT. Lease payments associated with these leases are expensed on a straight-line basis over the lease term. Irrecoverable VAT on lease payments is expensed as it falls due.

Subsequent measurement

As required by a HM Treasury interpretation of the accounting standard for the public sector, the Trust employs a revaluation model for subsequent measurement of right of use assets, unless the cost model is considered to be an appropriate proxy for current value in existing use or fair value, in line with the accounting policy for owned assets. Where consideration exchanged is identified as significantly below market value, the cost model is not considered to be an appropriate proxy for the value of the right of use asset.

The Trust subsequently measures the lease liability by increasing the carrying amount for interest arising which is also charged to expenditure as a finance cost and reducing the carrying amount for lease payments made. The liability is also remeasured for changes in assessments impacting the lease term, lease modifications or to reflect actual changes in lease payments. Such remeasurements are also reflected in the cost of the right of use asset. Where there is a change in the lease term or option to purchase the underlying asset, an updated discount rate is applied to the remaining lease payments.

Trust as a lessor

The Trust assesses each of its leases and classifies them as either a finance lease or an operating lease. Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

Finance Leases

Amounts due from lessees under finance leases are recorded as receivables at the amount of the Trust's net investment in the leases. Finance lease income is allocated to accounting periods to reflect a constant periodic rate of return on the Trust's net investment outstanding in respect of the leases.

Operating leases

Income from operating leases is recognised on a straight-line basis or another systematic basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised as an expense on a straight-line basis over the lease term.

Application of IFRS 16

IFRS 16 Leases was adapted and interpreted for the public sector by HM Treasury has been applied with an initial application date of 1 April 2022. IFRS 16 replaced IAS 17 Leases, IFRIC 4 Determining whether an arrangement contains a lease and other interpretations.

The standard was applied using a modified retrospective approach with the cumulative impact recognised in the income and expenditure reserve on 1 April 2022. Upon initial application, the provisions of IFRS 16 have only been applied to existing contracts where they were previously deemed to be a lease or contain a lease under IAS 17 and IFRIC 4. Where existing contracts were previously assessed not to be or contain a lease, these assessments have not been revisited.

The Trust as lessee

For continuing leases previously classified as operating leases, a lease liability was established on the 1 April 2022 equal to the present value of future lease payments discounted at the Trust's incremental borrowing rate of 0.95%. A right of use asset was created equal to the lease liability and adjusted for prepaid and accrued lease payments and deferred lease incentives recognised in the statement of financial position immediately prior to initial application. Hindsight has been used in determining the lease term where lease arrangements contain options for extension or earlier termination.

No adjustments have been made on initial application in respect of leases with a remaining term of 12 months or less from 1 April 2022 or for leases where the underlying assets has a value below £5,000. No adjustments have been made in respect of leases previously classified as finance leases.

Lease payments are apportioned between finance charges and repayment of the principal. Finance charges are recognised in the Statement of Comprehensive Income (SoCI).

The Trust determines the term of the lease term with reference to the non-cancellable period and any options to extend or terminate the lease which the Trust is reasonably certain to exercise.

1.16 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rates effective from 31 March 2025:

	Period	Rate	Prior Year Rate
Short-term	Up to 5 Years	4.03%	4.26%
Medium-term	After 5 years up to	4.07%	4.03%
Long-term	Exceeding 10	4.81%	7.72%

HM Treasury provides discount rates for general provisions on a nominal rate basis. Expected future cash flows are therefore adjusted for the impact of inflation before discounting using nominal rates. The following inflation rates are set by HM Treasury, effective from 31 March 2025:

	Rate	Prior Year Rate
Year 1	2.6%	3.6%
Year 2	2.3%	1.8%
Into perpetuity	2.0%	2.0%

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

Present obligations arising under onerous contracts are recognised and measured as a provision. An onerous contract is considered to exist where the Trust has a contract under which the unavoidable costs of meeting the obligations under the contract exceed the economic benefits expected to be received under it.

Early retirement provisions and injury benefit provisions both use the HM Treasury's pension discount rate of 2.40% (2023/24 2.45%) in real terms.

Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the Trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the Trust is disclosed at note 18.1 but is not recognised in the Trust's accounts.

Non-clinical risk pooling

The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to NHS Resolution and in return receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses when the liability arises.

1.17 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 18.2 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note 18.2, unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or

present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

1.18 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

The Secretary of State can issue new PDC to, and require repayments of PDC from, the Trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the Trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, with certain additions and deductions as defined in the PDC dividend policy issued by the Department of Health and Social Care. This policy is available at https://www.gov.uk/government/publications/guidance-on-financing-available-to-nhs-trusts-and-foundation-trusts.

In accordance with the requirements laid down by the Department of Health and Social Care (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

1.19 Corporation Tax

The Trust is a Health Service body within the meaning of s519A Income and Corporation Taxes Act (ICTA) 1988 and accordingly is exempt from taxation in respect of income and capital gains within the categories covered by this. There is a power for the Treasury to dis-apply the exemption in relation to specified activities of a Foundation trust (s519A (3) to (8) ICTA 1988). Accordingly, the Trust is potentially within the scope of corporation tax in respect of activities which are not related to the provision of health care. Where trading activities are undertaken that are commercial in nature the profits per activity are below the £50,000 corporation tax threshold as per the HMRC 'Guidance on the Tax Treatment of Non-Core Healthcare Commercial Activities of NHS Foundation Trusts.

1.20 Value Added Tax

Most of the activities of the Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.21 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the NHS foundation trust has no beneficial interest in them. However, they are disclosed in note 15.2 in accordance with the requirements of HM Treasury's *FReM*.

1.22 Financial assets and financial liabilities

Financial assets and financial liabilities arise where the Trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by ONS.

This includes the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements and are recognised when, and to the extent which, performance occurs, ie, when receipt or delivery of the goods or services is made.

1.22a Financial Assets

Recognition

Financial assets are recognised when the Trust becomes party to the contractual provision of the financial instrument or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are de-recognised when the contractual rights have expired or when the asset has been transferred and the Trust has transferred substantially all of the risks and rewards of ownership or has not retained control of the asset.

Financial assets are initially recognised at fair value plus or minus directly attributable transaction costs for financial assets not measured at fair value through profit or loss. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices, where possible, or by valuation techniques.

Financial assets are classified into the following categories: financial assets at amortised cost, financial assets at fair value through other comprehensive income, and financial assets at fair value through profit and loss. The classification is determined by the cash flow and business model characteristics of the financial assets, as set out in IFRS 9, and is determined at the time of initial recognition.

For all financial assets measured at amortised cost or at fair value through other comprehensive income, lease receivables and contract assets, the Trust will recognise a loss allowance, previously classified as impairment or bad debt provisions, representing expected credit losses on the financial instrument.

Financial assets measured at amortised cost are those held whose objective is to hold financial assets in order to collect contractual cash flows and where the cash flows are solely payments of principal and interest. This includes most financial assets at amortised costs and other simple debt instruments. After initial recognition, these financial assets are measured at amortised cost using the effective interest method, less any impairment. The effective interest rate is the rate that exactly discounts estimated future cash receipts through the life of the financial asset to the gross carrying amount of the financial asset.

Financial assets at amortised costs are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. They are included in current assets. The Trust's financial assets at amortised cost comprise current investments, cash and cash equivalents, NHS receivables, accrued income and 'other receivables'.

All other financial assets and financial liabilities are recognised when the Trust becomes a party to the contractual provisions of the instrument.

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income and a financing income or expense. In the case of loans held from the Department of Health and Social Care, the effective interest rate is the nominal rate of interest charged on the loan.

Impairment of financial assets

For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets or assets measured at fair value through other comprehensive income, the Trust recognises an allowance for expected credit losses.

The Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses. For other financial assets, the loss allowance is initially measured at an amount equal to 12-month expected credit losses (stage 1) and subsequently at an amount equal to lifetime expected credit losses if the credit risk assessed for the financial asset significantly increases (stage 2).

For other financial assets, the loss allowance is measured at an amount equal to lifetime expected credit losses if the credit risk on the financial instrument has increased significantly since initial recognition (stage 1), and otherwise at an amount equal to 12-month expected credit losses (stage 2).

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of estimated future cash flows discounted at the financial asset's original effective interest rate.

Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

De-recognition

Financial assets are de-recognised when the contractual rights to receive cash flows from the assets have expired or the Trust has transferred substantially all the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

1.22b Financial Liabilities

Financial liabilities are recognised when the Trust becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been extinguished — that is, the obligation has been discharged or cancelled or has expired. Loans from the Department of Health are recognised at historic cost. Otherwise, financial liabilities are initially recognised at fair value plus or minus directly attributable transaction costs for financial liabilities not measured at fair value through profit or loss.

After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method, except for loans from the Department of Health, which are carried at historic cost. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the amortised cost of the financial liability.

1.23 Losses and Special Payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had NHS trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

The losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

1.24 Charitable Funds

Under the provisions of IFRS 10 Consolidated Financial Statements, those Charitable Funds that fall under common control with NHS bodies are consolidated within the entity's financial statements. In accordance with IAS 1 Presentation of Financial Statements, restated prior period accounts are presented where the adoption of the new policy has a material impact. As the charitable income during the financial year 2024/25 was £86K, compared to the Trust's revenue of £404,524K, the funds are not considered sufficiently material for consolidated account to be prepared. The position is reviewed annually, to confirm whether or not the charity's funds are material enough for consolidation to be appropriate. Separate accounts for the NHS charity will be produced. An outline of the charity is as follows:

The Berkshire Healthcare Charity is registered with the Charity Commission under reference number 1049733. Trustees of the charity are also employees of the NHS foundation trust. Details of the charity can be obtained from www.charitycommission.gov.uk.

Note 2 Operating Segments

IFRS 8 'Operating Segments' requires disclosure of the results of the significant operating segments. A business or operating segment is a group of assets and operations engaged in providing core or non-core services that are subject to risks and returns that are different from those of other business or operating segments. In line with the standard, based on the internally reported activities, the foundation trust identifies that all activity is healthcare related and a large majority of the foundation trust's revenue is received from within UK government departments.

The Trust operates as a single operating segment. The Board of Directors, led by the Chief Executive is the Chief Operating Decision Maker within the Trust. It is only at this level that revenues are fully reported and the overall financial and operational performance of the Trust is assessed. As all decisions affecting the foundation trust's future direction and viability are made based on the overall total presented to the board, the foundation trust is satisfied that the single segment of healthcare is appropriate and consistent with the principles of IFRS 8.

Note 3 Operating income from patient care activities

Note 3.1 Income from patient care activities (by nature)

	2024/25	2023/24
	£000	£000
Mental health services		
Aligned payment & incentive (API) income	185,866	171,704
Services delivered as part of a mental health collaborative	2,161	2,122
Income for commissioning services from other providers as a mental health collaborative lead provider	801	-
Other clinical income from mandatory services	1,433	2,072
Community services		
Community services income from ICBs and NHS England	164,091	152,232
Community services income from other commissioners	13,059	13,256
All services		
Pay award central funding	133	73
Additional pension contribution central funding	18,112	10,845
Total income from activities	**385,656**	**352,304**

Note 3.2 Income from patient care activities (by source)

Income from patient care activities received from:	2024/25	2023/24
	£000	£000
NHS England (including central funding for AfC pay offer)	36,364	31,601
Integrated care boards	329,148	300,679
Local Authorities	15,208	14,854
Department of Health and Social Care	-	73
Other NHS foundation trusts	3,250	3,728
NHS Trusts	107	108
Injury cost recovery scheme	55	32
Non-NHS: other	1,524	1,229
Total income from activities	**385,656**	**352,304**
Of which:		
Related to continuing operations	385,656	352,304
Related to discontinued operations	-	-

Note 4 Other operating income

	2024/25	2023/24
	£000	£000
Other operating income from contracts with customers:		
Research and development	1,164	979
Education and training	6,940	8,565
Staff accommodation rental	65	70
Car Parking	87	82
Non-clinical services recharged to other bodies	204	227
Creche Services	2,267	1,988
Property Rental	3,948	3,867
Other income	4,147	4,322
Other non-contract operating income		
Contributions to expenditure - consumables (inventory) donated from DHSC group bodies for COVID response	-	48
Charitable and other contributions to expenditure	46	22
Total other operating income	**18,868**	**20,170**
Of which:		
Related to continuing operations	18,868	20,170
Related to discontinued operations	-	-

4.1 Additional information on contract revenue (IFRS 15) recognised in the period

	2024/25	2023/24
	£000	£000
Revenue recognised in the reporting period that was included in within contract liabilities at the previous period end	1,560	3,563
Revenue recognised from performance obligations satisfied (or partially satisfied) in previous periods	3,207	420

4.2 Transaction price allocated to remaining performance obligations

	2024/25	2023/24
Revenue from existing contracts allocated to remaining performance obligations is expected to be recognised:	£000	£000
- within one year	10,930	11,113
- after one year, not later than five years	-	-
- after five years	-	-
Total revenue allocated to remaining performance obligations	**10,930**	**11,113**

The Trust has exercised the practical expedients permitted by IFRS 15 paragraph 121 in preparing this disclosure. Revenue from (i) contracts with an expected duration of one year or less and (ii) contracts where the Trust recognises revenue directly corresponding to work done to date is not disclosed.

Note 4.3 Income from activities arising from commissioner requested services

Under the terms of its Provider License, the Trust is required to analyse the level of income from activities that has arisen from commissioner requested and non-commissioner requested services. Commissioner requested services are defined in the provider license and are services that commissioners believe would need to be protected in the event of provider failure. This information is provided in the table below:

	2024/25	2023/24
	£000	£000
Income from services designated (or grandfathered) as commissioner requested services	367,411	341,386
Income from services not designated as commissioner requested services	37,113	31,088
Total	**404,524**	**372,474**

Note 4.4 Total benefits obtained from the apprenticeship fund	2024/25 £000	2023/24 £000
Cash income received from the apprenticeship levy scheme where the Trust is accredited training provider	217	125
Total benefit obtained from the apprenticeship levy	**217**	**125**

Note 4.5 Operating Leases - Trust as a lessor

This note discloses income generated in operating lease agreements where the Trust is a lessor.

Lease receipts are in respect of the sub-lease with the following organisations and sites:

Organisaiton	Site
Royal Berkshire Hospitals NHS Foundation Trust	West Berkshire Community Hospital, Newbury and Erlegh House, Reading
Wokingham Borough Council	Resource House and 20 Denmark Street, Wokingham
Royal Borough of Windsor & Maidenhead	Abell Gardens, Maidenhead; Nicholson House, Maidenhead and 9 Allenby Road, Maidenhead
Sue Ryder Care	Greenham Trust Wing located at West Berkshire Community Hospital, Newbury
Health Intelligence Ltd	Diabetic Eye Screening sites across Berkshire
Dimensions (UK) Ltd	75 Kings Road, Reading, 222 Gosbrook Road, Reading and 351 Gosbrook Road, Reading

The majority of the operating lease income of £3,948K is received from Royal Berkshire Hospital NHS Foundation Trust where the original lease has expired but the occupancy continues under a 'tenancy-at-will' where the notice period is less than one year. All other operating lease income can either be supported by formal leasing agreement with the tenant, or a licence to occupy.

Note 4.6 Operating lease income

	2024/25 £000	2023/24 £000
Lease receipts recognised as income in year:		
Variable lease receipts	3,948	3,867
Total in-year operating lease income	**3,948**	**3,867**

Note 4.7 Future lease receipts

	31st March 2025 £000	31st March 2024 £000
Future minimum lease receipts due in:		
- not later than one year	3,447	3,378
- later than one year and not later than two years	75	75
- later than two years and not later than three years	-	36
- later than three years and not later than four years	-	-
- later than four years and not later than five years	-	-
- later than five years	426	378
Total	**3,948**	**3,867**

Note 5 Operating Expenses	2024/25	2023/24
	£000	£000
Purchase of healthcare from NHS and DHSC group bodies	3,476	4,640
Purchase of healthcare from non-NHS and non-DHSC group bodies	16,510	17,565
Mental health collaboratives (lead provider) - purchase of healthcare from NHS bodies	801	-
Employee expenses - executive directors	1,453	1,331
Employee expenses - non-executive directors	166	158
Employee expenses - staff	308,460	276,585
Supplies and services – clinical (excluding drugs costs)	8,218	6,849
Supplies and services - clinical: utilisation of consumables donated from DHSC group bodies for COVID response*	-	48
Supplies and services - general	1,008	892
Establishment	2,651	3,071
Research and development	224	263
Transport	2,071	1,992
Premises	18,641	17,864
Movement in credit loss allowance: contract receivables/assets	8	31
Increase/(Descrease) in other provisions	116	(568)
Change in provisions discount rate(s)	(22)	(29)
Drug costs	6,799	6,402
Rentals under operating leases (short term leases less than 12 months)	355	325
Depreciation on property, plant and equipment	10,071	9,554
Amortisation on intangible assets	983	1,285
Net Impairments	302	6,938
Audit fees payable to the external auditor:		
- audit services - statutory audit	225	195
- audit related assurance services	-	-
Internal Audit Fees	71	71
Clinical negligence premiums paid to NHS Resolution	1,650	1,912
Legal fees	786	788
Consultancy costs	164	404
Training, courses and conferences	891	2,263
Charges to operating expenditure for on-SoFP IFRIC 12 schemes on IFRS basis	8,463	8,347
Redundancy	27	129
Early retirements	8	(1)
Hospitality	9	4
Other services (external Payroll Services)	73	77
Losses, ex gratia & special payments	110	74
Other	3,236	3,013
Total	**398,004**	**372,472**
Of which:		
Related to continuing operations	398,004	372,472
Related to discontinued operations	-	-

Clinical supplies and services of £0K (2023/24 £48K) relates to centrally procured Personal Protective Equipment.

Note 5.1 Other auditor remuneration

The cost of other remuneration paid to the auditor, which included audit related assurance services were £0K (2023/24 £0K). Any fees are disclosed VAT exclusive.

Note 5.2 Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £2.0m (2023/24: £2.0m).

Note 6 Impairment of assets

	2024/25	2023/24
	£000	£000
Net impairments charged to operating surplus / deficit resulting from:		
Over specification of assets	-	-
Abandonment of assets in course of construction	-	-
Changes in market price*	33	6,038
Other**	269	900
Total net impairments charged to operating surplus / deficit	**302**	**6,938**
Impairments charged to the revaluation reserve***	3,472	38,716
Total net impairments	**3,774**	**45,654**

Impairments arising from change in market price are reductions in an asset valuation and where there is insufficient or no revaluation reserve to offset the reduction in value, resulting in the impairment being charged to the Statement of Comprehensive Income.

The ‘Other’ impairment of £269K is primarily arising from assets under construction brought forward from prior year based on an accured estimated cost, but the final amount paid is less due to discounts or recovery of VAT against a scheme under Contracted Out Service provisions as detailed in Section 41 of the VAT Act.

Impairments charged to the revaluaton reserve relates primarily to optimisation of the Modern Equivalent Assets under an alternative site model relating to the two PFI hospital sites of Prospect Park Hosptial in Reading and the West Berkshire Community Hospital in Newbury and the donated asset Greenham Trust Wing in Newbury. As part of the change in valuation estimation, the valuations of all three sites were impaired.

Note 7 Employee benefits

	Permanent	Other	2024/25 Total	2023/24 Total
	£000	£000	£000	£000
Salaries and wages	209,700	-	**209,700**	**186,551**
Social security costs	22,419	-	**22,419**	**20,853**
Apprenticeship levy	1,043	-	**1,043**	**975**
Employer's contributions to NHS pensions	45,937	-	**45,937**	**35,717**
Pension cost - other (NEST)	35	-	**35**	**49**
Other employment benefits	45	-	**45**	**-**
External Bank Staff	-	23,876	**23,876**	**26,214**
Agency/contract staff	-	7,812	**7,812**	**8,268**
Total gross staff costs	**279,179**	**31,688**	**310,867**	**278,627**
Included within:				
Costs capitalised as part of assets	954	-	**954**	**711**
Total employee benefits excl. capitalised costs*	**278,225**	**31,688**	**309,913**	**277,916**

* Total employee benefits relates to employees and Executive Directors, but excludes Non-Executive Directors

Note 7.1 Average number of employees (WTE basis)

	Permanent	Other	2024/25 Total	2023/24 Total
	Number	Number	Number	Number
Medical and dental	179	26	**205**	**204**
Ambulance staff	-	-	**-**	**-**
Administration and estates	586	21	**607**	**678**
Healthcare assistants and other support staff	1,776	249	**2,025**	**1,728**
Nursing, midwifery and health visiting staff	1,183	132	**1,315**	**1,249**
Nursing, midwifery and health visiting learners	24	-	**24**	**20**
Scientific, therapeutic and technical staff	941	41	**982**	**993**
Healthcare science staff	15	-	**15**	**13**
Other	1	-	**1**	**1**
Total average numbers	**4,705**	**469**	**5,174**	**4,886**
Of which:				
Number of employees (WTE) engaged on capital projects	11	-	**11**	**9**

Note 7.2 Retirements due to ill-health

The number of ill-health retirements in 2024/25 was 3 (2023/24: 3), with the value of early retirements on the grounds of ill-health being £79K (2023/24: £223K).

The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

Note 7.3 Directors' remuneration

The aggregate amounts payable to directors were:

	2024/25	2023/24
	£000	£000
Salary	1,291	1,231
Taxable benefits	0	0
Performance related bonuses	0	0
Employer's pension contributions	140	130
Total	**1,431**	**1,361**

The amounts shown reflect the cumulative salaries and employer pension contributions to directors, and excludes employer national insurance contributions

Further details of directors' remuneration can be found in the Remuneration Report.

Note 8 Finance income

	2024/25	2023/24
	£000	£000
Interest on bank accounts	3,370	3,228
Total	**3,370**	**3,228**

Note 8.1 Finance expenditure

	2024/25	2023/24
	£000	£000
Interest expense:		
Finance leases	212	152
Interest on late payment of commercial debt	-	-
Main finance costs on PFI	3,288	3,449
Remeasurement of PFI / other service concession liability resulting from change in index or rate	1,343	5,956
Total interest expense	**4,843**	**9,557**
Other finance costs	113	74
Total	**4,956**	**9,631**

Note 9 Other gains or (losses)

	2024/25	2023/24
	£000	£000
Gains / (Loss) on disposal of right of use assets (lease termination)	22	3
	22	**3**

Note 10.1 Intangible assets - 2024/25

	Software licences £000	Total £000
Valuation/gross cost at 1 April 2024 - brought forward	**7,031**	**7,031**
Additions	266	**266**
Reclassifications	504	**504**
Gross cost at 31 March 2025	**7,801**	**7,801**
Amortisation at 1 April 2024 - brought forward	**5,195**	**5,195**
Provided during the year	983	**983**
Amortisation at 31 March 2025	**6,178**	**6,178**
Net book value at 31 March 2025	**1,623**	**1,623**
Net book value at 1 April 2024	**1,836**	**1,836**

Note 10.2 Intangible assets - 2023/24

	Software licences £000	Total £000
Valuation/gross cost at 1 April 2023 - as previously stated	**12,190**	**12,190**
Additions	471	**471**
Impairments	(9)	**(9)**
Reclassifications	(1,301)	**(1,301)**
Disposals / derecognition	(4,320)	**(4,320)**
Valuation/gross cost at 31 March 2024	**7,031**	**7,031**
Amortisation at 1 April 2023 - as previously stated	**8,230**	**8,230**
Provided during the year	1,285	**1,285**
Disposals / derecognition	(4,320)	**(4,320)**
Amortisation at 31 March 2024	**5,195**	**5,195**
Net book value at 31 March 2024	**1,836**	**1,836**
Net book value at 1 April 2023	**3,960**	**3,960**

Note 10.3 Intangible assets financing 2024/25

	Software licences	Total
	£000	£000
Net book value at 31 March 2025		
Purchased	1,623	**1,623**
NBV total at 31 March 2025	**1,623**	**1,623**

Note 10.4 Intangible assets financing 2023/24

	Software licences	Total
	£000	£000
Net book value 31 March 2024		
Purchased	1,836	**1,836**
NBV total at 31 March 2024	**1,836**	**1,836**

Note 11.1 Property, plant and equipment - 2024/25

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2024 brought forward	**9,273**	**59,114**	**831**	**875**	**151**	**15,157**	**1,724**	**87,125**
Additions - purchased	-	1,767	3,852	438	173	4,090	822	**11,142**
Additions - IFRIC 12 scheme assets (excluding lifecycle)		51						**51**
Impairments charged to operating expenses	-	(66)	(153)	-	-	(83)	-	**(302)**
Impairments charged to revaluation reserve	(40)	(3,432)	-	-	-	-	-	**(3,472)**
Reclassifications	-	200	(678)	-	-	(26)	-	**(504)**
Revaluations*	310	(378)	-	-	-	-	-	**(68)**
Valuation/gross cost at 31 March 2025	**9,543**	**57,256**	**3,852**	**1,313**	**324**	**19,138**	**2,546**	**93,972**
Accumulated depreciation at 1 April 2024 - brought forward	**-**	**1,795**	**-**	**525**	**38**	**5,211**	**639**	**8,208**
Provided during the year	-	3,012	-	161	44	3,814	211	**7,242**
Revaluations*	-	(2,043)	-	-	-	-	-	**(2,043)**
Accumulated depreciation at 31 March 2025	**0**	**2,764**	**0**	**686**	**82**	**9,025**	**850**	**13,407**
Net book value at 31 March 2025	**9,543**	**54,492**	**3,852**	**627**	**242**	**10,113**	**1,696**	**80,565**
Net book value at 1 April 2024	**9,273**	**57,319**	**831**	**350**	**113**	**9,946**	**1,085**	**78,917**

Revaluations were performed on the 31st March 2025

Note 11.2 Property, plant and equipment - 2023/24

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2023 - as previously stated	**23,045**	**87,722**	**634**	**1,022**	**151**	**15,965**	**2,251**	**130,790**
Additions - purchased	-	3,039	657	67	-	5,415	324	**9,502**
Additions - assets purchased from cash donations / grants	-	22	-	-	-	-	-	**22**
Impairments charged to operating expenses	(4,112)	(2,621)	(143)	-	-	(42)	(11)	**(6,929)**
Impairments charged to revaluation reserve	(9,876)	(28,840)	-	-	-	-	-	**(38,716)**
Reclassifications	-	265	(317)	-	-	1,353	-	**1,301**
Revaluations**	216	441	-	-	-	-	-	**657**
Disposals / derecognition	-	(914)	-	(214)	-	(7,534)	(840)	**(9,502)**
Valuation/gross cost at 31 March 2024	**9,273**	**59,114**	**831**	**875**	**151**	**15,157**	**1,724**	**87,125**
Accumulated depreciation at 1 April 2023 - as previously stated	**-**	**1,787**	**-**	**582**	**6**	**9,510**	**1,184**	**13,069**
Provided during the year	-	2,980	-	157	32	3,235	295	**6,699**
Revaluations	-	(2,058)	-	-	-	-	-	**(2,058)**
Disposals / derecognition	-	(914)	-	(214)	-	(7,534)	(840)	**(9,502)**
Accumulated depreciation at 31 March 2024	**0**	**1,795**	**0**	**525**	**38**	**5,211**	**639**	**8,208**
Net book value at 31 March 2024	**9,273**	**57,319**	**831**	**350**	**113**	**9,946**	**1,085**	**78,917**
Net book value at 1 April 2023	**23,045**	**85,936**	**634**	**440**	**145**	**6,455**	**1,067**	**117,722**

**Revaluations were performed on the 31st March 2024

Note 11.3 Property, plant and equipment financing - 2024/25

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2025								
Owned	9,543	10,772	3,852	627	242	10,113	1,696	**36,845**
On-SoFP PFI contracts and other service concession arrangements	-	42,983	-	-	-	-	-	**42,983**
Donated	-	737	-	-	-	-	-	**737**
NBV total at 31 March 2025	**9,543**	**54,492**	**3,852**	**627**	**242**	**10,113**	**1,696**	**80,565**

Note 11.4 Property, plant and equipment financing - 2023/24

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2024								
Owned	9,273	10,739	831	350	113	9,939	1,085	**32,330**
On-SoFP PFI contracts and other service concession arrangements	-	45,887	-	-	-	-	-	**45,887**
Donated	-	693	-	-	-	7	-	**700**
NBV total at 31 March 2024 as restated	**9,273**	**57,319**	**831**	**350**	**113**	**9,946**	**1,085**	**78,917**

Note 11.5 Property plant and equipment assets subject to an operating lease (Trust as a lessor) - 31 March 2025

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Subject to an operating lease	602	1,115	-	-	-	-	-	1,717
Not subject to an operating lease	8,941	53,377	3,852	627	242	10,113	1,696	78,848
Total net book value at 31 March 2025	**9,543**	**54,492**	**3,852**	**627**	**242**	**10,113**	**1,696**	**80,565**

Note 11.6 Property plant and equipment assets subject to an operating lease (Trust as a lessor) - 31 March 2024

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Subject to an operating lease	568	1,063	-	-	-	-	-	1,631
Not subject to an operating lease	8,705	56,256	831	350	113	9,946	1,085	77,286
Total net book value at 31 March 2024	**9,273**	**57,319**	**831**	**350**	**113**	**9,946**	**1,085**	**78,917**

Note 11.7 Valuation methods for land and buildings - 2024/25

	Land	Buidings excluding dwellings
	£000	£000
DRC - Modern equivalent asset basis (alternative site)*	4,510	42,299
DRC - Modern Equivalent asset basis (no alternative site)	389	1,012
Market Value in existing use **	3,548	11,181
Fair value (surplus PPE land and buildings)	1,096	-
	9,543	**54,492**

* DRC - Modern Equivalent Asset (alternative site) is used for specialist land and buidings including the two PFIs at Prospect Park Hospital in Reading, West Berkshire Community Hospital in Newbury and Greenham Trust Wing located at West Berkshire Community Hospital.

** Depreciated historical cost is used as proxy for current value in existing use for certain leasehold improvement properties. The Net Book Value of these assets is £3,052K

Note 12 Leases - Berkshire Healthcare NHS Foundation Trust as a lessee

This note details information about leases for which the Trust is a lessee.

The Trust's main leases relate to:

- property for providing accommodation to both clinical and administrative services. This includes properties leased from NHS Property Services.
- transport equipment including employee and pool lease cars, and the Health Bus
- information technology in the form of data lines or network to link the Trust's remote clinical and admin locations and create a single IT infrastructure

	Property (land and buildings)	Transport equipment	Information technology	Total	Of which: leased from DHSC group bodies
	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2024 - brought forward	**17,654**	**439**	**2,101**	**20,194**	**6,707**
Additions - lease liability	149	83	982	**1,214**	-
Dilapidation provisions arising (capitalised in RoU asset)	113	-	-	**113**	-
Dilapidation provisions - change in discount rate	2	-	-	**2**	-
Dilapidation provisions - reversed unused	(434)	-	-	**(434)**	-
Remeasurements of the lease liability	275	-	(133)	**142**	107
Revaluations	8			**8**	
Disposals/derecognition - lease termination	(53)	(20)	(1,017)	**(1,090)**	-
Valuation/gross cost at 31 March 2025	**17,714**	**502**	**1,933**	**20,149**	**6,814**
Accumulated depreciation at 1 April 2024 - brought forward	4,295	319	359	4,973	2,776
Provided during the year	2,393	114	322	**2,829**	1,341
Reclassifications	-	(134)	134	**-**	-
Disposals / derecognition	(33)	(7)	(385)	**(425)**	
Accumulated depreciation at 31 March 2025	**6,655**	**292**	**430**	**7,377**	**4,117**
Net book value at 31 March 2025	**11,059**	**210**	**1,503**	**12,772**	**2,697**
Net book value of right of use assets leased from other DHSC group bodies*	2,697	-	-	**2,697**	

*Right of Use Assets leased from other DHSC group bodies includes property on lease with NHS Property Services Ltd, and include the Trust's hub sites of Upton Hospital in Slough, King Edward VII Hospital in Windsor, Wokingham Hospital in Wokingham, and St Mark's Hospital in Maidenhead. It also includes several other smaller sites in Berkshire and Hampshre, where the Trust provides healthcare services.

	Property (land and buildings)	Transport equipment	Information technology	Total	Of which: leased from DHSC group bodies
	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2023 - brought forward	**16,717**	**432**	**869**	**18,018**	**6,956**
Additions - lease liability	752	47	300	**1,099**	-
Dilapidation provisions arising (capitalised in RoU asset)	189	-	-	**189**	-
Dilapidation provisions - change in discount rate	78	-	-	**78**	-
Dilapidation provisions - reversed unused	(75)			**(75)**	-
Remeasurements of the lease liability	356	-	1,004	**1,360**	(216)
Disposals/derecognition - lease termination	(363)	(40)	(72)	**(475)**	(33)
Valuation/gross cost at 31 March 2024	**17,654**	**439**	**2,101**	**20,194**	**6,707**
Accumulated depreciation at 1 April 2023 - brought forward	2,214	227	89	**2,530**	1,391
Provided during the year	2,416	132	307	**2,855**	1,392
Disposals / derecognition	(335)	(40)	(37)	**(412)**	(7)
Accumulated depreciation at 31 March 2024	**4,295**	**319**	**359**	**4,973**	**2,776**
Net book value at 31 March 2024	**13,359**	**120**	**1,742**	**15,221**	**3,931**
Net book value of right of use assets leased from other DHSC group bodies	3,931	-	-	**3,931**	

Note 12.1 Reconciliation of the carrying value of lease liabilities

Lease liabilities are included within borrowings in the statement of financial position. A breakdown of borrowings is disclosed in note 18 Borrowings

	2024/25	2023/24
	£000	£000
Carrying value at 31 March 2024	**15,035**	15,185
Lease additions	1,214	1,099
Lease liability remeasurements	142	1,360
Interest charge arising in year	212	152
Early terminations	(687)	(66)
Lease payments (cash outflows)	(2,950)	(2,695)
Carrying value at 31 March 2025	**12,966**	**15,035**

Lease payments for short term leases, leases of low value underlying assets and variable lease payments not dependent on an index or rate are recognised in operating expenditure.

These payments are disclosed in Note 1.1 Operating Expenses. Cash outflows in respect of leases recognised on-SoFP are disclosed in the reconciliation above.

Note 12.2 Maturity analysis of future lease payments at 31 March 2025

	Total	Of which leased from DHSC group bodies:	Total	Of which leased from DHSC group bodies:
	31 March 2025	31 March 2025	31 March 2024	31 March 2024
	£000	£000	£000	£000
Undiscounted future lease payments payable in:				
- not later than one year;	2,812	1,372	2,656	1,348
- later than one year and not later than five years;	6,170	1,337	7,394	2,670
- later than five years.	4,720	-	5,739	-
Total gross future lease payments	**13,702**	**2,709**	**15,789**	**4,018**
Finance charges allocated to future periods	(736)	(22)	(754)	(52)
Net lease liabilities at 31 March 2025	**12,966**	**2,687**	**15,035**	**3,966**
Of which:				
Leased from other DHSC group bodies		2,687		3,966

Note 13 Inventories

	31 March 2025 £000	31 March 2024 £000
Drugs	323	312
Total inventories	**323**	**312**

Drug inventories recognised in expenses for the year were £2,190K (2023/24: £2,101K). Write-down of inventories recognised as expenses for the year were £0K (2023/24: £0K).

Note 14.1 Trade receivables and other receivables

	31 March 2025 £000	31 March 2024 £000
Current		
Contract receivables - NHS	5,806	3,138
Contract receivables - non NHS	3,881	3,065
Allowance for other impaired receivables	(91)	(83)
Prepayments (non-PFI)	2,663	2,214
PDC dividend receivable	-	1,648
VAT receivable	1,803	1,911
Clinician pension tax provision	7	6
Other receivables	142	169
Total current trade and other receivables	**14,211**	**12,068**
Non-current		
Clinician pension tax provision	185	180
Total non-current trade and other receivables	**185**	**180**

Note 14.2 Allowances for Credit Losses - 2024/25

	Contract receivables and contract assets	All other receivables
	£000	£000
Allowances as at 1 Apr 2024 - brought forward	**-**	**83**
New allowances arising	-	16
Reversals of allowances	-	(8)
Allowances as at 31 Mar 2025	**-**	**91**

Note 14.3 Allowances for Credit Losses - 2023/24

	Contract receivables and contract assets	All other receivables
	£000	£000
Allowances as at 1 Apr 2023 - brought forward	**-**	**83**
Allowances as at 31 Mar 2024	**-**	**83**

The Trust considers debt over 90 days and not under a payment plan or arrangement to be impaired.

Note 15.1 Cash and cash equivalents movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	2024/25	2023/24
	£000	£000
At 1 April	**52,612**	**55,196**
Net change in year	1,356	(2,584)
At 31 March	**53,968**	**52,612**
Broken down into:		
Cash in hand (ie Petty Cash)	6	8
Cash with the Government Banking Service	53,962	52,604
Total cash and cash equivalents as in SoCF	**53,968**	**52,612**

Note 15.2 Third party assets held by the NHS foundation trust

Berkshire Healthcare NHS Foundation Trust held cash and cash equivalents which relate to monies held by the Trust on behalf of patients or other parties. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	31 March 2025	31 March 2024
	£000	£000
Bank balances	2	2
Total third party assets	**2**	**2**

Note 16.1 Trade and other payables

	2025	2024
	£000	£000
Current		
Trade payables - NHS	145	509
Trade payables - Non NHS	2,903	4,611
Capital payables	3,556	2,349
Social security costs	2,839	2,704
VAT payable	418	195
Other taxes payable	2,593	2,223
Pension contributions payable	4,015	3,573
Other payables	833	666
Accruals - NHS	4,258	1,457
Accruals - Non NHS*	19,390	19,040
Total current trade and other payables	**40,950**	**37,327**

Accruals - Non NHS includes £1,228K (2023/24: £1,183K) for the value of untaken annual leave that has been accrued at the end of the financial year.

Note 16.2 Other liabilities

	31 March 2025 £000	31 March 2024 £000
Current		
Deferred income: contract liabilities	10,930	11,113
Total other current liabilities	**10,930**	**11,113**

Note 17 Borrowings

	31 March 2025 £000	31 March 2024 £000
Current		
Lease liabilities	2,629	2,523
Obligations under PFI, LIFT or other service concession contracts (excl. lifecycle)	4,061	3,682
Total current borrowings	**6,690**	**6,205**
Non-current		
Lease liabilities	10,337	12,512
Obligations under PFI, LIFT or other service concession contracts (excl. lifecycle)	39,528	42,360
Total non-current borrowings	**49,865**	**54,872**

Note 17.1 Reconciliation of liabilities arising from financing activities - 2024/25

	Lease liabilities £000	PFI schemes £000	Total £000
Carrying value at 1 April 2024	15,035	46,042	61,077
Cash movements:			
Financing cash flows - payments and receipts of principal	(2,733)	(3,796)	(6,529)
Financing cash flows - payments of interest	(217)	(3,288)	(3,505)
Non-cash movements:			
Additions	1,214	-	1,214
Lease Liability Remeasurements	142	-	142
Remeasurement of PFI / other service concession liability resulting from change in index or rate	-	1,343	1,343
Application of effective interest rate	212	3,288	3,500
Early terminations	(687)	-	(687)
Carrying value at 31 March 2025	**12,966**	**43,589**	**56,555**

Note 17.2 Reconciliation of liabilities arising from financing activities - 2023/24

	Lease liabilities £000	PFI schemes £000	Total £000
Carrying value at 1 April 2023	15,185	23,786	38,971
Cash movements:			
Financing cash flows - payments and receipts of principal	(2,570)	(3,591)	(6,161)
Financing cash flows - payments of interest	(125)	(3,449)	(3,574)
Non-cash movements:			
Application of IFRS 16 measurement principles to PFI liability on 1 April 2023	-	19,891	19,891
Additions	1,099	-	1,099
Lease Liability Remeasurements	1,360	-	1,360
Remeasurement of PFI / other service concession liability resulting from change in index or rate	-	5,956	5,956
Application of effective interest rate	152	3,449	3,601
Early terminations	(66)	-	(66)
Carrying value at 31 March 2024	**15,035**	**46,042**	**61,077**

Note 18 Provisions for liabilities and charges analysis

	Pensions - other staff	Injury Benefits	Legal claims	Redundancy	Capitalised Lease Dilapidations	Clinicians' pension reimburse-ment	Other	Total
	£000	£000	£000	£000	£000	£000	£000	£000
At 1 April 2024	**556**	**258**	**279**	**311**	**855**	**186**	**502**	**2,947**
Change in the discount rate	(12)	(11)	-	-	2	(2)	1	**(22)**
Arising during the year	39	-	494	172	113	3	50	**871**
Utilised during the year	(96)	(18)	-	(26)	-	(4)	-	**(144)**
Reversed unused	(53)	(43)	(151)	(211)	(434)	-	(181)	**(1,073)**
Unwinding of discount	90	24	-	-	(2)	9	1	**122**
At 31 March 2025	**524**	**210**	**622**	**246**	**534**	**192**	**373**	**2,701**
Expected timing of cash flows:								
- not later than one year;	97	18	622	246	-	7	123	**1,113**
- later than one year and not later than five years;	388	72	-	-	-	15	152	**627**
- later than five years.	39	120	-	-	534	170	98	**961**
Total	**524**	**210**	**622**	**246**	**534**	**192**	**373**	**2,701**

Pensions - Other Staff

This relates to former NHS employees whose contract of employment was terminated prior to their normal retirement age, with the effect that the employing authority became responsible for making up any shortfall in pension contributions as a result of that termination up until the death of either the former employee or any remaining survivor. The provision is adjusted annually, taking into Government Actuarial Department changes to life expectancy for England and Wales. Where the pension is no longer payable, then this is reversed unused.

Timing and expectation of the provision and future cashflows is based on historical payments to the NHS Pension Agency for pensions currently paid up to the end of each financial year.

Injury Benefits

This relates to injury benefits arising to individuals as a result of an accident at work, which is paid by the NHS Pensions Agency and then reimbursed by the Trust.

Timing and expectation of the provision and future cashflows is based on historical payments to the NHS Pension Agency for pensions currently paid up to the end of each financial year.

Legal Claims

This relates to claims made against the Trust but which are not covered by NHS Resolution, and can include employment related tribunal cases.

Redundancy

This relates to anticiapted costs in respect of redundancy in the Trust that as a result of a change management process where affected staff have been informed there is a risk there post will be terminated.

Dilpaidations (Capital)

This is for the risks associated with commercial leasehold properties where at the end of the lease there is a requirement to return the property to landlord in the same condition as it was prior to occupation.

Dilapidations are now split between capital and revenue. Capital dilapidations relate to asset held under a lease liability where the risk is capitalised against the Right of Use asset. Revenue dilapidations include the brought forward balance of dilapidations prior to IFRS 16 Leases being implemented, and any change in dilapidation risk for leasehold property that are outside of IFRS 16 - including short term leases of less than one year or where the lease had already ceased but the liability for the dilapidation is still be negotiated.

Other

Realtes to provisions in respect of Liability to Third Party ('LTPS') scheme claims against the Trust handled by NHS Resolution where the foundation trusts maximum exposure is £10,000 per claim. Historic dilapidation provisions previously charged to revenue prior to implementation to IFRS 16 in April 2022 are included here.

Note 18.1 Clinical negligence liabilities

At 31 March 2025, £10,246K was included in provisions of the NHS Resolution in respect of clinical negligence liabilities of Berkshire Healthcare NHS Foundation Trust (31 March 2024: £11,353K).

Note 18.2 Contingent assets and liabilities

	31 March 2025 £000	31 March 2024 £000
Value of contingent liabilities		
NHS Resolution legal claims	(22)	(14)
Gross value of contingent liabilities	**(22)**	**(14)**
Amounts recoverable against liabilities	-	-
Net value of contingent liabilities	**(22)**	**(14)**

Note 19 Contractual capital commitments

	31 March 2025 £000	31 March 2024 £000
Property, plant and equipment	-	157
Intangible assets	-	-
Total	**-**	**157**

Note 20 On-SoFP PFI, LIFT or other service concession arrangements

The foundation trust operates two PFI schemes:

Prospect Park Hospital, Reading Berkshire

This PFI scheme is to design, build, maintain and operate (through facilities management and related services) a 120 bed mental health inpatient hospital facility. The hospital became operational in March 2003. At the end of the contract the hospital buildings will revert to the Trust's ownership.

The contract has a 32 year term, ending in March 2033, and sees the Trust making a minimum unitary base payment that totals £4.02m annually. It is charged monthly and adjusted for RPI and according to any adverse performance against output measures describing all relevant aspects of the contract. Rates and utilities are borne separately by the Trust.

West Berkshire Community Hospital, Newbury, Berkshire

This PFI was originally managed by the former Berkshire West PCT prior to its dissolution on the 31st March 2013, when the PFI contract was transferred to the Trust. This facility operates services such as day case surgery and outpatient facilities. There are also a number of inpatient wards At the end of the PFI contract the hospital building will revert to the Trust's ownership.

The contract has a 32 year term, ending in July 2032. The Trust makes a minimum unitary base payment that totals £1.46m annual. It is charged monthly adjusted for RPI, and according to any adverse performance against output measures describing all relevant aspects of the contracts. Rates and utilities are borne separately by the Trust.

Both PFI contracts were deemed as off-balance sheet when the Full Business Cases were approved prior to their design and construction. Following adoption of IFRS the Trust considers the contracts under IFRIC 4 Determining Whether an Arrangement Contains a Lease and IFRIC 12 Service Concession Arrangements and recognised the schemes as 'on-Statement of Financial Position'.

The substance of the two contracts is that the Trust has a finance lease and annual payments comprise three elements - finance lease rental, service charges and replacements of the asset components (lifecycle replacements). The element of annual finance lease rental is further split into three components: repayment of the finance lease principal, a finance cost and contingent rental representing the inflation increases. An annual finance cost is calculated by applying the implicit interest rate in the lease to the opening lease liability for the period. The implicit rate of interest for Prospect Park Hospital is 7.31%, whilst for West Berkshire Community Hospital it is 6.61%.

Total obligations for on-statement of financial position PFI contracts due:

Note 20.1 Imputed finance lease obligations

	31 March 2025 £000	31 March 2024 £000
Gross PFI, LIFT or other service concession liabilities	**58,125**	**63,392**
Of which liabilities are due		
- not later than one year;	7,084	6,880
- later than one year and not later than five years;	29,449	28,229
- later than five years.	21,592	28,283
Finance charges allocated to future periods	(14,536)	(17,350)
Net PFI, LIFT or other service concession arrangement obligation	**43,589**	**46,042**
- not later than one year;	4,061	3,682
- later than one year and not later than five years;	20,475	18,219
- later than five years.	19,053	24,141

Note 20.2 Total On-SoFP PFI, LIFT and other service concession arrangement commitments

Total future payments committed in respect of PFI, LIFT or other service concession arrangements	31 March 2025 £000	31 March 2024 £000
	138,783	**150,475**
of which due:		
- not later than one year;	15,822	15,436
- later than one year and not later than five years;	68,566	65,555
- later than five years.	54,395	69,484
	138,783	**150,475**

Note 20.3 Payments committed in respect of the service element

	31 March 2025 £000	31 March 2024 £000
Charge in respect of the service element of the PFI, LIFT or other service concession arrangement for the period	**80,658**	**87,083**
Commitments in respect of the service element of the PFI, LIFT or other service concession arrangement:		
- not later than one year;	8,738	8,556
- later than one year and not later than five years;	39,117	37,326
- later than five years.	32,803	41,201
Total	**80,658**	**87,083**

Note 20.4 Analysis of amounts payable to service concession operator

	31 March 2025 £000	31 March 2024 £000
Unitary payment payable to service concession operator (total of all schemes)	**15,547**	**15,387**
Consisting of:		
- Interest charge	3,288	3,449
- Repayment of finance lease liability	3,796	3,591
- Service element	8,463	8,347
Total amount paid to service concession operator	**15,547**	**15,387**

Note 21 Financial instruments

Note 21.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the NHS trust has with clinical commissioning groups and the way those clinical commissioning groups are financed, the NHS foundation trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The NHS foundation trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the NHS trust in undertaking its activities.

The Foundation Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Foundation Trust's Standing Financial Instructions and policies agreed by the Board of Directors. Foundation Trust treasury activity is subject to review by the Trust's internal auditor.

The Foundation Trust's financial instruments, other than those used for treasury risk management purposes, comprise cash and liquid resources and various items such as trade debtors and creditors that arise directly from its operations. The Trust does not undertake speculative treasury transactions.

Liquidity risk

The Foundation Trust's net operating costs are mainly incurred under legally binding contracts with local Clinical Commissioning Groups, NHS England and local authorities, which are financed from resources voted annually by Parliament. Under Payment by Results, the Foundation Trust is paid for activity on the basis of nationally set tariffs. For contracted activity, the Foundation Trust is paid in 12 monthly instalments throughout the year, which significantly reduces the Foundation Trust's liquidity risk. Performance in excess of contracted levels is paid in accordance with the terms of the legally binding contracts. The Foundation Trust finances its capital programme through internally generated resources and external borrowing where appropriate.

Foreign currency risk

The Foundation Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and Sterling based. The Trust has no overseas operations therefore the exposure to currency rate fluctuations is low.

Interest-Rate Risk

None of the Foundation Trust's financial assets or liabilities carries any real exposure to interest-rate risk. The Foundation Trust's owned assets are funded by public dividend capital, which is non-interest bearing and of unlimited term. The PFI assets, are funded by way of a Finance Lease which are at a fixed rate of interest over the full remaining term of the PFI contracts.

Credit Risk

Due to the fact that the majority of the Trust's income comes from legally binding contracts with other government departments and other NHS Bodies the Trust does not believe that it is exposed to significant credit risk. The maximum exposures as at 31st March 2025 are in receivables from customers, as disclosed in the Note 14.1 Trade and other receivables.

Note 21.2 Carrying values of financial assets

	Loans and receivables £000	Total £000
Carrying value and fair value of financial assets 31 March 2025		
Embedded derivatives	-	**-**
Trade and other receivables excluding non-financial assets	9,596	**9,596**
Cash and cash equivalents at bank and in hand	53,968	**53,968**
Total at 31 March 2025	**63,564**	**63,564**

	Loans and receivables £000	Total £000
Carrying value and fair value of financial assets 31 March 2024		
Trade and other receivables excluding non-financial assets	6,120	**6,120**
Cash and cash equivalents at bank and in hand	52,612	**52,612**
Total at 31 March 2024	**58,732**	**58,732**

Note 21.3 Financial liabilities

	Other financial liabilities £000	Total £000
Liabilities as per SoFP as at 31 March 2025		
Obligations under leases	12,966	**12,966**
Obligations under PFI, LIFT and other service concession contracts	43,589	**43,589**
Trade and other payables excluding non-financial liabilities	30,252	**30,252**
Other financial liabilities	-	**-**
IAS 37 provisions which are financial liabilities	995	**995**
Total at 31 March 2025	**87,802**	**87,802**

	Other financial liabilities £000	Total £000
Liabilities as per SoFP as at 31 March 2024		
Obligations under leases	15,035	**15,035**
Obligations under PFI, LIFT and other service concession contracts	46,042	**46,042**
Trade and other payables excluding non-financial liabilities	27,966	**27,966**
IAS 37 provisions which are financial liabilities	781	**781**
Total at 31 March 2024	**89,824**	**89,824**

Note 21.4 Maturity of financial liabilities

	31 March 2025	31 March 2024
	£000	£000
In one year or less	40,891	37,904
In more than one year but not more than five years	35,725	35,775
In more than five years	26,409	34,249
Total	**103,025**	**107,928**

Note 21.5 Fair values of financial assets at 31 March 2025

	Book value	Fair value
	£000	£000
Trade and other receivables excluding non-financial assets	9,596	9,596
Cash and cash equivalents at bank and in hand	53,968	53,968
Total	**63,564**	**63,564**

Note 21.6 Fair values of financial liabilities at 31 March 2025

	Book value	Fair value
	£000	£000
IAS 37 provisions which are financial liabilities	995	995
Obligations under leases	12,966	12,966
Obligations under PFI, LIFT and other service concession contracts	43,589	43,589
Other	30,252	30,252
Total	**87,802**	**87,802**

Note 22 Losses and special payments

	2024/25		2023/24	
	Total number of cases	**Total value of cases**	**Total number of cases**	**Total value of cases**
	Number	**£000**	**Number**	**£000**
Losses				
Cash losses	4	0*	-	-
Fruitless payments			1	1
Bad debts and claims abandoned	1	0*	2	0*
Stores losses and damage to property	-	-	1	1
Total losses	**5**	**-**	**4**	**2**
Special payments				
Extra contractual to contractors	-	-	3	16
Losses of Personal Effects	9	2	6	4
Personal Injury with Advice	7	52	2	9
Other Employment	1	8	4	56
Other Ex-gratia Payments	1	0*	1	6
Total special payments	**18**	**62**	**16**	**91**
Total losses and special payments	**23**	**62**	**20**	**93**

Where the number of cases is equal to one or more, but the value of cases is £0, the amount of the cumulative losses is less than £500.00. The value is returned as £0 due to rounding.

Note 23 Related parties

Berkshire Healthcare NHS Foundation Trust is a body corporate established by order of the Secretary of State for Health.

During the year none of the Board Members or members of the key management staff or parties related to them has undertaken any material transactions with Berkshire Healthcare NHS Foundation Trust.

The foundation trust considers material transactions as those being where the income or expenditure is over £250,000 per annum.

The Department of Health is regarded as a related party. During the year Berkshire Healthcare NHS Foundation Trust had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department. These entities are listed below:

	Income		Expenditure		Receivables		Payables	
	2024/25	2023/24	2024/25	2023/24	2024/25	2023/24	2024/25	2023/24
	£000	£000	£000	£000	£000	£000	£000	£000
NHS Foundation Trusts								
Central and North West London NHS Foundation Trust	3	-	-	319	-	-	-	-
Frimley Health NHS Foundation Trust	401	597	2,012	1,699	423	571	434	722
Oxford Health NHS Foundation Trust	2,769	2,444	257	271	248	236	82	120
Oxford University Hospitals NHS Foundation Trust	331	427	55	52	-	17	-	-
Royal Berkshire NHS Foundation Trust	6,818	6,531	3,206	3,143	2,984	325	3,320	519
South Central Ambulance Services NHS Foundation Trust	176	422	158	157	-	-	-	26
Sussex Partnership NHS Foundation Trust	2	-	1,608	-	-	-	7	-
University Hospital Southampton NHS Foundation Trust	394	-	-	-	218	-	-	-
Integrated Care Boards								
NHS Frimley ICB	129,888	120,518	5	-	893	92	5	1,547
NHS Buckinghamshire, Oxfordshire and Berkshire West ICB	198,736	179,407	70	470	971	1,606	4,229	6,186
NHS England and other associated organisations								
NHS England - Core	7,833	6,075	319	135	16	13	1,795	1,223
South West Regional Office	-	4,336	-	-	-	-	-	-
South East Regional Office	12,684	12,045	-	-	16	-	-	-
Other NHS Bodies								
NHS Resolution	-	-	1,802	2,045	-	-	10	-
NHS Property Services Ltd	-	122	5,698	4,266	14	85	27	-
Department of Health and Social Care	-	476	9	7	-	103	-	-
Local and Unitary Authorities								
Bracknell Forest Borough Council	4,254	4,081	38	41	191	407	18	41
Reading Borough Council	6,603	6,630	22	113	549	550	303	398
Slough Borough Council	1,176	1,157	333	211	770	602	201	5
West Berkshire Council	155	534	39	52	206	210	116	149
Windsor and Maidenhead (Royal Borough of)	333	335	51	74	10	10	20	89
Wokingham Borough Council	2,651	2,141	138	95	980	409	233	219
Other Whole of Government Account Organisations								
HM Revenue & Customs - VAT	-	-	-	-	1,803	1,911	418	195
HM Revenue & Customs - Other taxes and duties and NI contributions	-	-	23,462	21,828	-	-	5,432	4,927
NHS Pension Scheme	-	-	45,937	35,717	-	-	4,051	3,604
NHS Professionals	-	-	-	-	-	-	-	4,188
Berkshire Health Charitable Fund	15	15		-		-		-
Total	375,222	348,293	85,219	70,695	10,292	7,147	20,701	24,158